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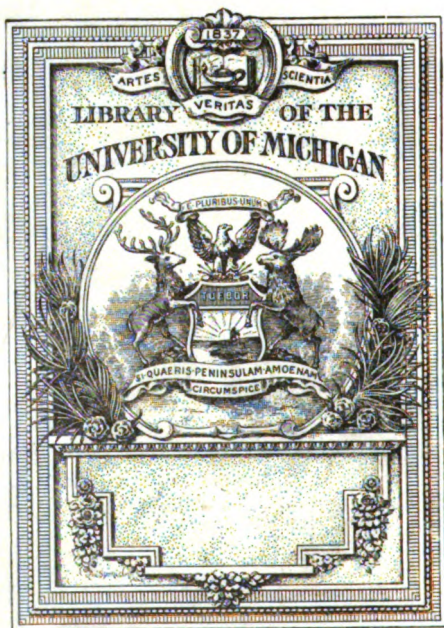
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# THE HOMŒOPATHIC JOURNAL OF OBSTETRICS, GYNÆCOLOGY AND PÆDOLOGY.

A. L. CHATTERTON, EDITOR AND PUBLISHER.

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## COMMONPLACE MIDWIFERY.\*

BY

GEORGE WILLIAM WINTERBURN, M.D.,  
NEW YORK.

I went some time ago on a pilgrimage. Glowing accounts had come to me of the almost miraculous success, and of the wonders to be seen, at the Sloane Maternity, where the goddess of Listerian cleanliness reigns in unmitigated asperity; and the half was not told me. *Vidi*. Which being rendered into the vernacular means that I was shown everything, from kitchen to garret.

As probably all the members of this Society have heard of this Maternity, and few have seen it, a brief description of my visit may not be uninteresting. That day there were present in the wards 25 patients; 10 post-partum. Two deliveries had taken place that morning, and another labor was announced while I was in the building. The average time of a patient in the institution is twenty days; twelve post-partum.

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\* Presented to the Bureau of Obstetrics of the Homœopathic Medical Society of the County of New York, November 14, 1889.

The woman on arriving at the institution is taken into the basement and thoroughly scrubbed, inside and out; her clothes are taken from her, and she is provided with a new, disinfected hospital suit, her own being baked in a temperature of 500° Fahr., and put away until she is ready to go out. One ward is kept empty at all times, and the patients are rotated from ward to ward in such a way that each ward is only used ten days, when everything, except the iron bedsteads, is removed and replaced with new, and the walls and flooring scrubbed and disinfected; this entails an enormous expense. Everything is plain but substantial, the atmosphere of purity and quiet is very tranquillizing, and the nurses are fair and comely to look upon. The lying-in women seemed to be doing well, except one who had just been confined, but the babies all had a dusky look, which I thought might be owing to the pervasive odor of carbolic, kreasote and iodoform.

There have been about 600 cases in the institution. The death-rate is about in the ratio of one to one hundred and thirty-five, which coincides with the usual statistical statements issued from similar institutions, and is moderate in consideration of the necessity they are frequently under of taking mismanaged midwife and other emergency cases. But the mortality among the babies is excessive, nearly in the ratio of one to nine; though I was told recent experience is better than formerly. The mother receives a small glass of milk every two hours during the first day, and soft food for the next four or five; she is kept in bed about seven or eight days. The child is washed when it is twelve hours old, and it is then put to the breast; the navel is dressed with bismuth et iodoform; the average weight at birth 7.3 lbs. The McLane forceps are used; they have Tarnier's (possibly others), but do not use them; perineal lacerations are frequent. The doctor and assistants, matron and nurses, cook and laundresses, and other employees, make a total of twenty-five; about the same as the number

of patients. The expenses are frightfully large; counting the interest on the plant, about ninety dollars per case. Taking into consideration the restful quietude of the place, the orderliness and the cleanliness, I do not see that much can be claimed for antisepsis. I looked over a large number of the "record" sheets, and while they present an excellent showing, yet fever, eclampsia, and other obstetrical accidents do occur.

It is pleasant to know that we have in our midst an institution so beneficent in intent and so exemplary in conduct, and in the interest of helpless, wronged, fate-accursed womanhood we may hope that this Christ-like charity may enlist the co-operative sympathy of others as capable as Mr. Sloane of providing the wherewithal. I wish we could have just such an institution in every ward of our city; though institutional charity is, alas, often deadening to the sensibilities of those who administer it, and gilded misery to those for whose benefit it is arranged. I could not help asking myself as I came away, How long can the Sloane Maternity continue to defy the law of thrift, that of accomplishing results with the least expenditure? but this is a question that outsiders are not called upon to solve.

But it was not of other men's work of which I desired to speak to you to-night. When your Chairman did me the honor to ask that I should appear before you he suggested a number of topics: Indications for Craniotomy—Cæsarian Section—The Use of the Forceps—Placenta Prævia—but while any of these would have proved interesting topics ten or twelve years ago, I found it impossible to awaken within myself any special enthusiasm for any one of them in particular. As for the "indications for craniotomy," I am glad to say that I never cracked anybody's skull—not even a defenseless infant's; as for "Cæsarian section," I know a man, at least a lawyer, who says he never was born, but I never helped any one to get into the world in that irregular way;



"forceps" I have used and will speak of them later on ; "placenta prævia," I had one case, and that I muddled disastrously.

In groping about in my mind for a text upon which to build this paper, there was ever present with me the feeling that this society was entitled to my best ; and what better could I offer it than the plain tale of my own commonplace experience. It is of this, therefore, that I would speak ; of midwifery services rendered mainly to the humble, the distressed, the blighted ; services hardly worth recounting for their own sake ; but that which has cost me ten thousand hours of anxiety may furnish one hour's interest to you.

Mr. John Morley, in his "Diderot and the Encyclopædists," relates of his hero that one of his friends had an aversion for women with child. "What monstrous sentiment !" Diderot wrote ; "for my part that condition has always touched me. I cannot see a woman of the common people so, without a tender commiseration." These words struck a responsive sentiment within me, and I find the drudgery of midwifery not only bearable but indeed enjoyable from the sympathy which the condition arouses within me. Diderot continues : "The bit of coarse canvas that covers her, the hair falling about her cheeks, the rags and poor short skirt that go no more than half-way down her legs, the naked feet covered with mud—all these things do not wound me ; 'tis the image of a condition that I respect, 'tis a sign and summary of a state that is inevitable, that is woful, and that I pity with all my heart."

To us living in this community, so absorbed in its material necessities, so ruled by the "goddess of getting-on," these words come as an incentive and a benediction. I do not know how it may be with others, though it has sometimes seemed as if the average sentiment of the profession toward obstetrical work was one of tolerance rather than of liking. I do not believe that that is the best spirit in which to approach any work ; nor is any worthy work done

worthily in which the heart is not. In this, as in every department of human endeavor, different men pursue their allotted tasks, and embrace their opportunities, from different motives ; most often without perceiving the real trend of their intention. Of opportunity it may be said,

" To some she is a goddess great :  
To some the milch-cow of the field ;  
Their business is to calculate  
The butter she will yield."

But in midwifery the man who cannot say, in all humbleness but truly, of his work, " This is the best of me ; for the rest, I ate, and drank, and slept, loved, and hated, like another ; this, if anything of mine, is worth your memory,"<sup>1</sup> will leave behind him, in the gathering years, shattered constitutions and bereaved hearths as silent witnesses of misplaced confidence—misplaced because it rested in him.

It is now something more than a decade and a half since I first witnessed the ushering of a new life into mundane activities. I presume we all remember our first experiment in obstetrical practice, but to me that first experience held one moment of supreme terror which a myriad of subsequent commonplaces could not obliterate. Like most fresh young men I wanted a case, but when suddenly called upon to assume the responsibility—I rather wished I hadn't. The groans and complaints of the woman assailed my unaccustomed ears ; the perturbation of the husband, who was also undergoing a first experience, disturbed my equanimity ; while the inconsequential gabble of several female friends, whose rotundity bespoke experience which I would gladly, at that moment, have bought with a price, added to the confusion. My own jejuneness of experience was not suspected, and matters gradually progressed with me in the rôle of Fabius Maximus. I had read, only the day before, with anxious preoccupation of mind, all about the proper pro-

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<sup>1</sup> " Sesame and Lilies," by John Ruskin, page 18.

ceeding, on the part of the accoucheur, during the first, the second, and the third stage of labor ; but I found myself rather embarrassed as to what stage we were in, until the increasing cries of the parturient made obvious that a crisis of some sort had arrived. I hurriedly turned down the sheet, and my affrighted eyes saw protruding from the bulging vulva a dark, unctuous mass, which resembled a piece of corrugated liver. My excited imagination swept out of recollection all the anatomical and obstetrical lore I ever knew, and for one solitary instant reigned supreme ; but, in another moment, the hand of Ananke thrust out into the world a mass of black hair well anointed with vernix caseosa, and the head of a man-child was born into the world.

In no department of human exertion are the rewards of success and the pains of failure more certain and more potent than in midwifery. The babe was born, and the doctor was adjudged skillful by the accordant voices of mother, husband, and friends. Their praise was balm to my wounded self-esteem ; and I can look back now, through the vista of experience, on that night with amusement, if not with complacency. But my trouble was not ended. There was still a placenta, whose obdurate impassiveness exhausted all my skill (sic) for the space of three hours, and nearly wrecked my recent cheaply bought honors. However, everything was at last disposed of, and my night of adventure came to an end with the first peep of daylight. I escaped from the house as one set free from damning peril, and the sun rose on me and a reviving world.

Since that direful night I have had some experience, and I trust have learned something ; at least a well-covered poll, barbered *au naturel*, no longer affrights me. The nature of that experience may be gathered from the following statement, though statistical information conveys, at the best, only half-truths. As in this instance, it does not show the subsequent history of the woman and child as



related to the labor in question. To say so and so many women were brought to bed means little unless we can know how they were brought out of it; whether with damaged health or renewed vigor. We must know not only the mortality but the morbidity.

Whole number of cases (1874-1889), 617 :

1 para.....	215	8 para.....	11
2 ".....	136	9 ".....	8
3 ".....	103	10 ".....	6
4 ".....	76	11 ".....	2
5 ".....	32	12 ".....	3
6 ".....	14	13 ".....	1
7 ".....	9	14 ".....	1
Total.....			617

Number to whom preparatory treatment was given, 367.

The amount of preparatory treatment varied greatly; in some cases only one prescription was given, in others the treatment extended through the entire epoch of pregnancy. The large number of cases in which an opportunity was afforded for preparatory treatment was secured by letting it be known that we would not accept cases at the dispensary unless the engagement was made at least two months in advance. And while we did occasionally break this rule, the enforcing it led in many instances to a pre-engagement of four or five months, especially as we gave the further inducement of free treatment during the ante-parturient epoch. The dispensary charge was only ten dollars; but in many cases (40 in one year) this was altogether remitted, and in others partially.

Number of times attendant on same woman : Once, 428; twice, 102; thrice, 64; four times, 13; five times, 7; six times, 2; total, 617.

The large number of single confinements was due to the fact that a large portion of these were dispensary engagements; and the migratory habits of that class are well known.

Twin pregnancy, 3.

Oldest 1-para<sup>3</sup>—37 years 4 months.

Youngest 1-para<sup>3</sup>—15 years 3 months.

Sex of children : Male, 329; female, 288; total, 617.

Presentations : Head, 598. Vertex : O.L.A., 517; O.D.A., 23; O.D.P., 41; O.L.P., 12. Brow 3. Face 2. Arm (including shoulder), 3. Breech (including footling), 13. Transverse, 2. Undelivered, 1. Total, 617.

Placenta prævia, 1.

Deaths ; Mother (placenta prævia), 1; Child (1 shoulder, 1 transverse), 2.

Forceps used, times,<sup>4</sup> 64; Chloroform used, times,<sup>5</sup> 121.

The brow and face presentations are hard to rectify, and impossible after once the head is jammed down into the pelvis. The two face presentations occurred within a month of each other. The first I did not discover as early as I ought to have done, and it had to be born in face position, under chloroform. The head was shockingly disfigured, but the child lived. In the other case I made out the face before the rupture of the membranes, and, having the nurse push the breech forward, I forced the chin upward, and slowly shifted it to the O.D.A position.

I have credited myself with three brow positions ; but as this is difficult, in fact the most difficult of all the head positions to make out early, and as it was changed, or seemed to be changed, in each case to a vertex position, I will not argue with any one who thinks I was mistaken ; it is enough that the woman was safely delivered and the child was born alive.

The manipulation of these cases requires two capable assistants ; one to lift, with both hands, the uterus bodily, the other to press, with the hands, upward and inward from

<sup>3</sup> And it was a tough one.

<sup>4</sup> She had two living children and three miscarriages before her seventeenth birthday.

<sup>5</sup> Including 17 times in consultation cases.

<sup>6</sup> Including ether, and ether, chloroform and alcohol. In a number of forceps cases, at the outlet, no anæsthetic was used.

outside the brim of the pelvis, while the accoucheur makes pressure within the os, which will vary according to the position of the child in the uterus. The woman must lie upon the side to which the foetal back is turned.

It has ever been my endeavor, since engaging in obstetrical work, to narrow mechanical interference to cases in which it was actually unavoidable, and not merely to those in which it seemed so; to lessen the resort to instruments, more and more, as I learned the wonderful capabilities of the human hand as a diagnostic weapon and as a parturifacient; and to make this latter, by trusting to it and taking counsel with it, as intelligent for the purpose as possible. I have no desire to laud myself, and small warrant for it if I had the desire; therefore, if I speak of my own work it is only with the hope that I may hand on to others, in some measure, the results of the experience which has been allotted to me.

There is no royal road in obstetrics, as far as I have been able to discover. The same qualities which make a good homœopathic physician make a good obstetrician, provided he loves this branch of work. If I have had more than the usual amount of success, and avoided some of the perils of which I hear so much, this is due to the careful and minute study of each case in all its surroundings. When a woman comes to engage me to attend her in confinement, I do something more than book the date. I am a firm believer in the power of homœopathic medication in midwifery, and am sure that the science of the day<sup>6</sup> has little

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<sup>6</sup> Illustrative of the growth of scientific medical opinion see the London *Lancet*, for Aug. 24, 1888, in which is tentatively advanced the idea of the contagiousness of diabetes. Drs. Debove, Lecorché and, six other members of the Société Médicale des Hôpitaux, record numerous cases of what they call conjugal diabetes; and the simultaneous appearance of this disease in husband and wife awakens in the minds of these scientists the idea of contagiousness, or the probability of it. Contagion includes, of course, the idea of a coccus. This interesting little diabète has not yet been discovered, but will be, sure; for witness the latest conclusions as to pneumonia.

The argument as to the contagiousness of pneumonia is not new, but it has

to offer to a true homœopathic physician. Labor is a physiological experience, and manipulation and instrumentation are no necessary parts of it; though they may be made so by unphysiological living. But I am now speaking of those cases which we have under view from the beginning of pregnancy, and in which there is not irremediable organic defect. Of course, if after nine months of mismanagement and neglect we are called upon to take charge of a well-

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reached now the phase of scientific demonstration. Netter (*Archives Générale de Médecin*) has caught the little rascalion, and made him give an account of himself. We old fogies who thought that taking cold had something to do with pneumonia are all wrong. Netter finds that not only is pneumonia a contagious disease of parasitic origin, and is transmissible either directly or by the intervention of a third person, or by inanimate objects, such as wearing apparel, bedding, etc., but that the pneumococci are not destroyed by desiccation, though probably never surviving more than three years, and are diffused through the air to the distance of three hospital beds; rather an uncertain quantity, as most of us neglect to carry a hospital bed around with us as a measuring rule. Moreover, they are so malignantly vital that they are found in the saliva of post-pneumonics many years after the attack, so that the person remains a living terror to all his friends who approach within three hospital beds of him. But, worse and worse, this continuing vitality of the pneumococci accounts for the recurrence of the disease in individuals who have survived it. Not only can a person who has once had pneumonia communicate it to his wife and children years afterward, but he can reinfect himself, renewing the cycle of contagion; which thus rivals Tennyson's brook in unmitigated continuousness. This truly scientific doctrine is now making the circuit of the earth; it can be found cropping out, now here, now there, in current medical literature, thanks to discreet editorship.

But the most stupendous exhibition which scientific medicine has made of itself in recent years is its hallucination in regard to dimethylochinizin, better known as antipyrin, and other synthetical derivatives from coal-tar. Invented by Knorr, in 1884, patented in every country, it became a source of phenomenal income to its lucky discoverer, and a source of disaster to the sick of every clime. Heralded as a panacea for all morbid conditions; excessively praised and gratuitously advertised by the wise men of Paris and Berlin, of London and New York, of Vienna and San Francisco; extensively used in the most heterogeneous conditions, its supposed phenomenal virtues interpreted variously according to the preconceptions of would-be explainers; the actual knowledge as to its precise physiological action could be written on a bit of paper the size of a baby's hand, while the mass of literature which its use has called into existence,

advanced case of labor, we must adapt treatment to circumstances; though even here much may be done; if I said how much I believe might be done I would be considered fanatical by many worthy practitioners.

**PREPARATORY TREATMENT.**—Much has been written on proper preparation for labor. As to the ordinary suggestions about food and hygiene, I say nothing in this place, but

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the chief characteristic of which is a general inclination towards disagreement and contradiction, would fill an alcove in Astor Library.

It has been my misfortune to lose several friends through the murderous efficiency of this drug in the hands of well-known scientific doctors; a fact which has contributed doubtless to my interest in its fantastic history. One case in particular, in which the actors were all well-known men, comes up most vividly before me as I write. The patient was an ex-army surgeon, who, during the war of '61, was gradually advanced to one of the highest positions in the medical service, having charge at one time of six large hospitals in and near Washington. He was a man of commanding presence, and great physical endurance, with a mind broadened by contact with life in all its phases. He had been an intimate friend of my father for many years, and, like Agrippa, almost persuaded to accept the new (medical) faith. Somehow he must have passed somebody in the street who had had pneumonia within three years, for one day in February, 1886, having been exposed in a violent rain-storm, he thought he took cold (what a zany)! and so gave himself a sweat. But the next day he was quite ill; and his daughter called in Prof. —, a well-known alienist, who was in the house, and he called in Prof. —, a famous gynecologist, and he Prof. —, a widely recognized authority on diseases of the chest; and they sat in solemn conclave. It afterwards transpired that doctor number one offered his services, and the daughter not thinking her father very ill, and having no one at hand with whom to advise, as they lived among the Berkshire hills, and were merely transients in the city, accepted the offer.

Antipyrin was just beginning to be noised about as the latest fad in medicine and so instead of the whisky, iron and quinine, hitherto the medical armaments of the said chest specialist, antipyrin was afforded an opportunity. Dr. C., my sick friend, sent for me to come over and see him, and I went; at least I went as far as six feet inside the front door, when I was met by one of the attending physicians, who cordially informed me that it was thought best by the medical counsel that I should not see Dr. C., not even socially. I, however, was informed as to the line of treatment; that he had had a phenomenally high temperature,  $105^{\circ} + \text{Fahr.}$ , I believe, but that he had had several 30-grain doses of antipyrin, and the temperature was now about normal. The wonderful virtues of antipyrin were dwelt upon. To anticipate any further resistance

confine attention to the more purely medical aspects of the case ; not but that I appreciate those, while having to content myself with things as I find them. The majority of people in New York have to live, by force of circumstances, amid unhygienic surroundings, and with less and poorer food than is good for them ; that this is their own fault mostly, makes it no less evident, and no less true. That is, it

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on the part of nature, they were about to administer another 30-grain dose. The next day, I was told, he seemed to be in a state of collapse, but that his temperature was all right. But the collapse passed into the moribund, and with the on-coming twilight of a bleak, brief winter day, my good doctor joined the majority. How many similar histories might be written to the credit of scientific medicine ; of its frantic endeavors to lower the temperature, with fatal additions to the death rate.

Already the ultra-scientist is on the lookout for something to replace this group of hypothetical exalgsics ; but Knorr need not despair. The public have heard of the wonder-working substance ; deaf, indeed, they must have been if they had not ; and it has joined the great procession of noxious agents, morphine, chloral, avena, which any druggist will dispense to any comer, with money in his hand. In the "upper circles," however, antipyrin, and to a less extent, because less famous, its congeners also, are now looked upon with distrust. Semmola declares that the administration of these antipyretics produces a poisonous rather than a medicinal effect, the repose secured being at the expense of vital force. In Bright's disease it has proved suddenly fatal, even when given, as supposed, cautiously and in small doses ; though here, as elsewhere, "untoward results, not a few of them lethal, are of much more common occurrence than is generally known or admitted." *The Medical Age*, Oct. 25, 1889, page 404, says : "It is now considered as established that this reduction of temperature is the result of *diminished production of heat*, and consequently of enfeebled or diminished vitality due to some action upon the heat center situated in the corpus striatum. Metabolism is markedly checked, and the volume of urea diminished ; diaphoresis ensues, but in no way explains the fall of temperature ; and the reflex excitability of the spinal cord is greatly depressed, ultimately, as a result, leading to anæsthesia." These facts ought to be well known, but they do not seem to be. Leading pharmacists inform me that prescribing antipyrin is still, apparently, a favorite occupation, and growing in favor ; the bulk of the profession do not read.

Nevertheless, antipyrin is doomed. As in society so in medicine, it is not the commonalty that set the fashion ; and on Olympus antipyrin is no longer spoken of in terms of praise. But let not the scientific heart falter ; already somebody is cogitating, and soon the trumpet of fame will blazon a new name, and the acme of professional erudition will be revealed—for a time.

is their fault collectively, communally ; the individual is helpless.

The chemical treatment, by which it is sought to prevent calcifying of the foetal bones, so that their suppleness will aid quick and easy parturition ; and the moderate-eating treatment, which is intended to reduce the growth of the foetus unnaturally, so that by its small size labor may be expedited, I have seen tried ; though never fascinated by that especial form of foolishness myself. Whatever weakens the woman will cause lingering and painful labor. Some of the worst cases I have had have been those in which the child weighed less than six pounds.

On the other hand I have tried the use of calisthenics, and especially the health-lift pretty thoroughly in a number of cases ; and have induced other doctors to do the same. The idea that muscularity and painless parturition stood in relation to each other as cause and effect seemed plausible. I was loath to abandon it, but I have. Not but what I believe moderate artificial exercise, with which may be included massage, will do good when used under careful supervision ; but cases which have received the most scrupulous watchfulness, in this regard, have yet in the critical hour proved anything but expeditious and painless. Again, on the other hand, in the large majority of cases the advantages derived from the health-lift seemed manifest ; and I recommend it in cases where the financial abilities of the patient make the expenditure of no especial consequence.

The use of mitchella repens to facilitate labor has given me great satisfaction ; but it is rather difficult to determine how much credit is due to a drug under these circumstances. The labor might have proven easy without medicinal interference ; and even in the case of a woman who, having had two or three tedious or painful labors, is given mitchella, and its exhibition is followed by an unusually easy delivery, we cannot definitively determine that the mitchella deserved the credit. I have seen too many multiparæ in which a

difficult labor succeeds an easy one, or *vice versa*, not to be cautious in the application of any aphorism. While in no one case can we say positively that mitchella, cimicifuga, pulsatilla, cyclamen, or the remedy given, did actually promote painless parturition, yet the general trend of experience leads me to believe that much is accomplished when the therapeutic agent is wisely chosen. Not every case will profit by mitchella, nor can I say always why I give it, except that the "still, small voice" within affirms the choice; but, in general, mitchella is demanded when by previous experience a tedious labor is anticipated, and when the present condition is one of depressed spirits without the loss of sleep, with tardy digestion, much flatulence, and dulled sensorium. My manner of using it is to leave with the patient a small vial of the first decimal dilution, with instruction to dissolve ten drops in a couple of ounces of water, and take in divided doses during the course of the day. When so given, during the eighth or ninth month, the delivery has always been easy. I have kept no record of the number of cases in which I have used it, but judging by recollection, and the present state of the pound bottle of the fluid extract which I bought, of Parke, Davis and Co., in August, 1878, and from which I have prepared all my dilutions, I should say the number somewhat exceeded seventy, and, by a singular idiosyncrasy of mine, they were all multiparæ. Primaparæ I have always prepared for labor by the use of calcarea, sulphur, thuja, pulsatilla, cyclamen, cimicifuga, and in rarer cases by other medicaments.

When I notice that a woman, about to become a mother, looks pale and wan, that her hair is unnaturally dry, that her teeth sometimes ache, that she has a little, teasing dry cough, and other evidences of deficient secondary assimilation and of trophic debility, I give calcarea 30, once a week; adding, in some cases, powdered bone to her dietary. When without any positive symptom of disease I notice a lethargy



of the entire system, the functions performed, but performed tardily, I give sulphur (sometimes 6, 30, 200, or cm.); occasionally preceding this, when I want to make a sharp impression, by a nine day course of the old-fashioned sulphur, cream of tartar and molasses. The administration of a crude drug heightens the subsequent sensitiveness of the system to its dynamic action in infinitesimal doses.

A first pregnancy brings to the surface many latent ills, whose evidence may be so indeterminately expressed as to escape attention; but we ought to be on the watch for these, mindful of the frailties of human nature. Thuja is a grand remedy in some of these cases, and under its influence for a week or two, I have seen a young woman suddenly bloom out, in the early months of pregnancy, like a rose-bush under the June sun. Yes, I hear some one say, who hasn't, and without thuja? But I mean cases which, to the experienced eye, show a buried taint, which needs something more than love and maternity to uproot. Thuja, under these circumstances, and after experimenting with potencies, I give in tincture, one, two, or three drops daily, in divided doses.

Pulsatilla needs neither comment nor commendation. You all know its influence in correcting the minor ailments of the last weeks of pregnancy. I recollect hearing my father say, as long ago as 1865 or '66, that its alleged power in preventing or correcting mal-position was through its influence on the bowels of the foetus, causing fermentation of the meconium, and ballooning of the abdomen by gas. Schultz has shown, by his salt water and alcohol experiment, that immediately after birth the breech is heavier than the head, under ordinary circumstances. And I can testify to the fact, observed many times, that in cases in which the mother has taken pulsatilla for several weeks prior to confinement, the babe is almost sure to have a movement of the bowels quickly after birth, and often just at the moment of delivery. As, in other cases, several hours are apt to elapse before a

movement occurs, this would seem to indicate some influence on the part of pulsatilla.

The following rather amusing instance may serve to "point a moral," or may merely "adorn a " pointless "tale." I was engaged to attend a 3-para in August, 1881. When the engagement was made she said: "Oh, doctor, I wish you could give me something so that I wouldn't have to suffer so long." Enquiry developed the fact that in previous labors the pains had been extremely distressing but ineffectual, the labors lasting one or two days. She, of course, was not able to distinguish between "first stage," and "second stage," or to give any very satisfactory particulars, except that she was firm in the belief that she had suffered more than her share. I replied, with due professional suavity: "Yes, I can do that much for you anyway." So about a month before the expected time I sent her a package of pulsatilla 30 powders, with instructions to take one every night on going to bed. On Sunday morning, August 21, I was sent for, while I was eating my breakfast. Remembering her tale of tedious labor, I finished my breakfast somewhat leisurely, mindful that dinner might be uncertain, and then gathering together my obstetric paraphernalia went over to her house, which was on the next block. The first sound which assailed my ears as I went into the room was the squall of a new-born, and I soon learned that, feeling rather heavy and distressed, she was sitting on the lounge, when having a premonitory pain she started for the bed, but a severe pain seized her before she got there, and the child was born on the edge of the bed, and not respectably and decorously in it as well-mannered children are wont to be. After removing the secundines, and getting the mother tidied up, I was just leaving my final instructions, when she looked up into my face and said, with an innocence of expression and tone which I was in doubt whether to understand as concealing a latent sarcasm: "I think, doctor, your powders act almost a little too quick."

It is only in a minority of our cases that we have an opportunity of watching the course of pregnancy from the beginning, or near the beginning. Especially are we hampered in our treatment of first pregnancies. Young married women seem to consider pregnancy a crime, or at least an unfortunate accident, to be hidden from view as long as possible. It is a sensible mother, whose daughter, about to share in the universal experience, entrusts her to the guidance and oversight of a wise physician. At this crisis of physical experience nature is very mobile, she yields to the gentlest suggestions, and the various ills inherited from maculate ancestry may now be modified, corrected, or removed. But, alas, mothers are rarely sensible, and physicians are not always wise.

**THE FIRST STAGE.**—In spite of numerous theories which have been promulgated we are in entire ignorance of the reason why labor occurs at a fixed epoch. That it does so occur we not only have the consent of universal experience, but in extended pregnancies the added time seems always to be one or two lunar months. Thus in a case, 1-para, to which I was called in consultation by Dr. Thos. Newby, in February, 1879, I declined to use forceps, as the condition of the woman did not, in my opinion, demand instrumental interference, although she had been, more or less, in "pain" for two days. The pains gradually died out, and on the twenty-eighth day thereafter she was delivered, naturally and easily, of a boy weighing nearly nine pounds. So, also, in another case, in Brooklyn, the wife of a music teacher, 5-para, became pregnant at the middle of August, 1883. On May 10, 1884, labor commenced, and the pains at one time were severe, but the uterus was anteverted to such an extent that the os could not be felt by digital examination. On the second day the pains gradually ceased. Delivery was effected on July 5, just fifty-six days later, after an easy labor lasting three hours. The child, a girl, weighed eight

pounds, thirteen ounces. The mother is quite diminutive.

Whatever may be the immediate provocative of parturition, there can be little doubt that the initiatory force lies in the uterine parietes, and that the first stage of labor is purely the contraction of the uterus upon itself, accompanied by a stretching and thinning of the lower segment. But in the second stage observation compels me to award more than accessory influence to the effort of voluntary muscles. In this I go beyond what seems to be usual opinion, and coincide nearly with the views advanced by Haughton, of Dublin.\*

The sum of the muscular force exerted during this stage of labor is very much greater than is usually supposed. A woman of average muscular ability, with the feet supported and the diaphragm fixed, will exert traction with each hand of from sixty to one hundred and ten pounds during the crisis of the second stage. This I have ascertained by numerous experiments. And while the force so expended does not in itself expedite the movements of the fœtus, it is an exemplification of the immense forces in action at the moment. The amount of this available force, exerted by the abdominal muscles, as well as the muscular force of the uterine parietes, has been calculated by Haughton, by Lagrange's formula,<sup>8</sup> as follows :

$$P = T \times \left( \frac{1}{\rho} + \frac{1}{\rho'} \right)$$

in which P represents the sum of the forces acting on one square inch perpendicularly to the membrane; T, the tensile strain on one inch broad, acting tangentially to the surface, of the membrane; and  $\rho$  and  $\rho'$  denote the radii of the principal curvatures of the membrane at the point consid-

\* "On the Muscular Forces employed in Parturition: their Amount and Mode of Application," by Rev. Samuel Haughton, M.D., in *The Dublin Quarterly Journal of Medical Sciences*, May, 1870.

<sup>8</sup> *Mécanique Analytique*, page 147.

ered. The force  $P$  arises from hydrostatical pressure within the uterus. If the surface is spherical, or becomes so, then

$$P = \frac{2T}{\rho} \quad (2.)$$

Now if we assume the uterus to be a prolate ellipsoid 12 inches long by 8 inches across, its mean curvature will equal that of a sphere whose diameter is 9.158 inches. The volume of the gravid uterus is expressed by the formula

$$V = \frac{4}{3} \pi a b^2$$

in which  $V$  stands for volume,  $\pi$  for the ratio between the circumference and diameter, and  $a$  and  $b$  the semiaxes. Substituting for  $a$  and  $b$  their numerical value, the contents of the uterus is shown to be 402.13 cubic inches, and the surface 270.66 square inches. these figures differ somewhat from those deduced by various authorities, but they are accurate enough for the purpose.

The mean weight of the muscular fiber of the uterus at term is 1.56 pounds, and its mean thickness 0.1519 inch. Now a cubic inch of muscular fiber will lift 102.55 pounds; and this multiplied into 0.1519 equals 15.577 pounds.

. . . if in equation 2 we substitute these values,  $T = 15.577$ , and  $\rho = 9.158$ , the maximum hydrostatic pressure produced

by uterine contraction  $= \frac{2 \times 15.577}{9.158} = 3.402$  pounds to the square inch. The mean rupturing pressure of the membranes, as determined by Duncan and Tait,\* is 1.2048 pounds, and the maximum 3.1 pounds. Thus we have a maximum power of 3.4 to overcome a maximum resistance of 3.1; certainly a beautiful adjustment of means to an end, and exemplification of the Law of Thrift. It would be a waste of force to endow the uterus with more power than is necessary to complete the first stage, as the abdominal muscles already exist, and can be advantageously used.

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\* "Researches in Obstetrics." New York: William Woods and Co. 1868.

The average area of the pelvic canal is  $\pi \times 4.5$  inches, which multiplied by the pressure  $3.402 = 54.106$  pounds, the extreme force exerted by the uterus in parturition. The force required to expel the foetus has been calculated by various experimenters, and the mean value is about 100 pounds, equal to a hydrostatic pressure inside the uterus of 6.28 pounds to the square inch. But though this hydrostatic pressure is very much beyond the effort of the unaided uterus to overcome, yet there is no danger of injury to that organ, as its rupturing strain varies from 17 to 25 pounds to the square inch.

By an interesting mathematical calculation Haughton has shown that the force exerted by the abdominal muscles is equal to 32.926 pounds to the square inch, and this multiplied into  $4.5 \times \pi = 523.65$ , the maximum muscular effort exerted by the abdominal muscles over the pelvic area. This mathematical induction was verified by experiments upon two men, each of whom was able to exert a force, using the abdominal muscles only, of 38.47 pounds to the square inch. The experiments were pushed to the point of producing slight peritonitis in each case.

Playfair brings forward to negative this the instance of inertia of the uterus, when voluntary action is incapable of producing delivery.<sup>10</sup> But no one would claim that muscular power can be applied to the whole surface of a patulous uterus in such a way as to void its contents; and Playfair is certainly wrong in assuming that the whole structure would collapse under the pressure indicated by Haughton, for Dr. George Winship, the Boston strong man, has conclusively demonstrated that a force of 4000 pounds may be applied to the abdominal region without its being crushed by the strain.

[To be Continued.]

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<sup>10</sup> "Midwifery," page 167. Macmillan, 1889.

## REMARKS ON ABDOMINAL SURGERY, SUGGESTED BY THE CLINIC OF MR. LAWSON TAIT.

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BY

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It is undoubtedly true, that the present tendency in medicine is toward the practice of specialties. The requirements of medical science are daily becoming more and more exacting, and it is now generally recognized by both the profession and the laity, that the field is too large an one to be compassed in a single lifetime; that the essentials for perfection,—and upon this matter the public is quite as exacting as ourselves,—are so manifold, including an intimate knowledge of many collateral branches of science, that the best work can only be accomplished by devoting one's energies toward a single object. The effect of this upon the individual can scarcely fail to be opposed to that broad culture which we almost instinctively associate with the physician; but while the individual may thus suffer, I am confident that the world will be richer; and, after all, it is what we give to others, and to posterity, rather than what we are ourselves, that makes us great or small,—that justifies our life.

The specialist in England has more of the confidence of the general practitioner, than with us in America. I do not here refer to confidence in the professional ability of the specialist, but rather to his honesty in dealing with the patients placed under his care. The reason for this, I believe I am right in ascribing to the more exact boundary lines dividing the specialist from the general practitioner that obtain there. This being generally understood, pub-

lic opinion, whatever individual inclination may be—for there is no reason to believe that the English practitioner is more to be trusted than his American brother—is against the continuation of professional relations after the special treatment has been discontinued. I am inclined to think that much of the unwillingness shown by the general practitioner to place his patient under the care of a specialist arises from the fact that the specialist is not strictly one; that he is willing, when there is a sufficient inducement offered, to be still regarded as a general practitioner.

This state of affairs, which happily is fast changing, is most unfortunate for the patient, who is thus made a victim of the very person in whom the utmost confidence should be placed, for there is no question that one's life and health are safer in the hands of the surgeon, for example, when surgical treatment is required, than in the hands of the "family doctor," and in many cases, delay of what must come at last—an operation—increases the risk to life, multiplies the difficulties of the surgeon, and not infrequently places the unfortunate patient beyond the reach of his skill.

In no department of medicine is this more true than in abdominal surgery. Here the difference between delay and prompt surgical treatment is frequently equivalent to an easy or an exceedingly difficult operation, with corresponding risks to life. And delay nowadays has another significance than inaction, in cases of abdominal tumors. I believe it would be fortunate for the patient if this were all it meant. I refer to the use of electricity in the treatment of abdominal tumors. It is true the patients are sent to specialists, but these practitioners are middle-men; men occupying a position half-way between the general practitioner who acknowledges that he cannot remove the tumor, and the surgeon who believes that it must come out, and has the courage to perform the operation. I will not here enter into a discussion of electricity. I am not an



electrician, nor am I prepared to argue the strength of the current necessary to decompose a fibroid tumor. Quite recently I heard this question thoroughly canvassed by two very eminent English electricians, their opinions differing to the extent of two hundred millampères, showing that considerable still remains to be learned in the use of electricity. While I may have theories concerning the use of electricity for abdominal tumors, my opposition to it in these cases entirely arises from clinical experience, and I may say that, without an exception, those cases that have finally come to an operation, either removal of the appendages or of the tumor, have been among the most difficult operations that I have seen—much more difficult than the post-operative history would lead one to expect. In the majority of such cases the adhesions are so dense as to seem almost inseparable, the effect of the electricity being to mat together in one mass all the pelvic organs. The effect of this, even if the tumor is removed, cannot be much better than the original disease, and surely when the case comes to an operation the complications are increased by this experimental treatment, and the woman is in consequence deprived of some of her few chances of recovery.

During the past few months with Mr. Lawson Tait, I have had abundant opportunity to confirm a growing conviction that the treatment of abdominal tumors by electricity is productive of no permanently good results, and is pernicious in its effect upon a future operation. Now that the treatment has been sufficiently tested to obtain results, Mr. Tait is almost daily in receipt of letters from women in America, as well as from all over Europe, who have had electricity tried, and in whom it has failed either to reduce the tumor, or suffering,—indeed frequently increasing the latter,—who desire to come to him for operation. He has also, within a period of three months, operated upon a number of women who have been so treated, and without an exception we found the most universal adhesions, of an extent that prob-

ably would not have existed had not the case been tampered with. If for any reason an abdominal tumor cannot be operated upon, I believe it is better to do nothing, than to use electricity. While in England, I went over this question very thoroughly, from the side of published statistics, from my own experience, and from the vast material furnished me by Mr. Tait, and I have yet to find the case in which an undoubted myoma of the uterus has been entirely removed by electricity, or to find a case operated upon, that does not present complications reasonably traceable to the use of this agent ; and I am more than ever convinced that it is the duty of surgeons to protest against this dangerous method of treatment ; not particularly dangerous in itself, though a few deaths have been recorded, but prejudicial to the success of the only treatment that can cure, removal of the appendages, or a hysterectomy.

But to return to simple delay in operating upon abdominal tumors. What possible advantage can be gained by procrastination? I venture to say, none. The cases in which abdominal tumors have disappeared spontaneously are quite too hypothetical to justify the surgeon in waiting for such an issue. If there is a tumor, there is only one certain method of dealing with it—an operation. I do not here include all diseases of the ovaries and tubes that develop swellings. The treatment of these will sometimes admit of delay, when the symptoms are not very severe, and when the patient's social condition will allow the necessary rest. But I very much question whether even this delay for the purpose of trying some less radical measures will be as frequent in the future as it is at present ; for these cases of damaged appendages, almost without exception, ultimately require an operation. And save for the risk to life, which is now comparatively slight, the operation had better be done as soon as it becomes certain that a cure cannot otherwise be affected ; the women are sterile already, and removing the ovaries does not in any sense unsex them. Even if

it did, where is there a man who for his own gratification would deny his wife relief from suffering? Surely, if such a one exists, we may take off our hats to the brutes, for they at least respect the wishes of their females. But in point of fact, the majority of women with damaged appendages are debarred all sexual relations from the excessive suffering which the act causes, and there is therefore no excuse on that score for delaying an operation. And here let me say one word in reference to the frequently expressed criticism upon Mr. Tait, that he operates upon cases without due consideration; indeed, that he operates upon every case that comes to him. From what I have seen of his work, this criticism is far from the truth. No man is more careful in making a diagnosis, though he reaches one in less time, and by means not familiar to the majority of surgeons: none more unwilling to resort to an operation if other means will suffice. I have seen cases in his clinic, of damaged appendages that have been under his constant treatment for one and two years, and so long as there is the least improvement, the operation is delayed. Again, I have known many women sent to him with a history pointing to diseases of the appendages and with a request for an operation. His remarkable power of diagnosing diseases of the ovaries and tubes by an examination, and his almost occult power of separating false from true symptoms, satisfies him that nothing will be gained by an operation, and he returns the patient with words of encouragement, and with a verbal message calculated to increase, rather than to diminish, her confidence in her family physician.

If nothing is gained by delaying a necessary abdominal operation, the reverse picture is equally true, something is as certainly lost. As the tumor increases in size, it usually forms new points of adhesion, which increase the difficulty, as well as the risk of the operation. One of Mr. Tait's recent cases demonstrated the truth of this. It was a large myoma, the removal of which had been delayed from time

to time. We found that the principal source of nourishment was the omentum, so firm had the adhesions grown, one of the arteries having attained quite the size of the radial artery.

The former belief that it is better to leave an ovarian tumor until it has reached a certain size, is in the present state of abdominal surgery not true, for the smaller the tumor the easier and less dangerous is the operation. The earliest period is the best for any operation, and this rule is as true of the abdomen as of other regions of the body.

This brings me to another note on abdominal surgery,—the unity of surgical law. There is not one law for the knee-joint, another for the cranium, and still another for the abdomen. Absolutely the same laws and principles of surgery, and of operative surgery, obtain in one region that hold good in another. According to the fundamental principles of all operative surgery, that pathological structures and conditions interfering with function or threatening life should be removed, or changed as speedily as circumstances permit. The abdominal cavity is a perfectly legitimate field for the exercise of the surgical art. The touch-me-not feeling that prevailed regarding the peritoneum has been greatly done away with, and save upon the question of early interference, there is at present among the more advanced school little difference of opinion concerning the propriety of removing uterine and ovarian tumors. But the battle still is being fought, and on the plaintiff's side, at least, in no measured terms, over the necessity of operating upon tumors of other abdominal organs, and especially the pathological conditions of the Fallopian tubes. It seems difficult to reconcile this persistent opposition with the surgeon's duty, or with the fundamental principles of his profession. As Mr. Tait, in discussing this question with me, said: "No true surgeon would willingly leave a suppurating body in the eyes, the knee, or the chest; why then should he leave one in the abdomen?" And I answered then, as I answer now:

"There is every reason why he should not do so. The general law to remove pus and suppurating bodies, is, if possible, more true of the abdomen than almost any other region of the body, for here the bursting of an abscess will almost certainly be followed by a fatal peritonitis. And again, viewing the question from the patient's standpoint: On one side we have a life of misery, sterility, and sexual incapacity; on the other, we have a life of comfort, of course sterility, but with the capacity for and enjoyment of marital relations."

Those who have seen these damaged appendages after removal—and this has been more forcibly impressed upon me during my summer with Mr. Tait, for he operated upon a large number of cases while I was with him—and have followed the cases before and after the operation, cannot, it seems to me, if they have not come to the conclusion *a priori*, fail to give their sanction to the operation. There is no doubt that the operation has been done when not called for; but this kind of work belongs to that class of would-be surgeons who do many unnecessary operations, and has no part with the masters in our art, or the truly conscientious surgeons. I again quote Mr. Tait: "God forgive me for my mistakes, but if I am ever called upon to answer to a charge of neglected duty, it will be that I have not operated often enough, rather than I have operated too often; for as I retrospect, I see many lives that might have been saved had I given them the chances offered by an abdominal operation."

As is well known, Mr. Tait in his practice discards what is usually called antiseptic surgery, believing that it is not only useless, but actually harmful. I am, however, obliged to say, that nothing that I saw while with him discouraged me from the use of these methods. I neither advocate nor allow in my surgery the extreme antiseptic practice, but feeling that I cannot exclude disease elements without some antiseptic, I use them to such an extent as to insure cleanliness.

## LEUCORRHŒA IN VIRGINS.—SOME OF ITS CAUSES.—SUGGESTIONS AS TO TREATMENT.

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BY

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The twentieth century is the woman's century, said Victor Hugo, and verily woman is rapidly assuming new responsibilities, entering on new vocations, attaining many great successes. As she gains physical strength, does she fulfill with greater ease the primary object of her existence? Are the carefully cultured maidens of the present day as robust as could be desired, preparing as they are to be mothers of the nation? Are they stronger than their grandmothers? These questions should be answered in the affirmative, if we are confidently to expect good results from our modern methods of culture.

Let the members of the Bureau of Gynæcology and Obstetrics answer. The specialists in the diseases of women will tell us the harvest in that field is richer every year, and the obstetrician will declare, that except for the oblivion wrought by chloroform the parturient woman of to-day is not one whit better off than Eve when she first bore a child in accordance with the curse pronounced upon her! The maladies which beset womankind seem to be legion, and I have chosen as my subject the affliction which of all others is most troublesome to the physician. Hydra-headed malady, we have for leucorrhœa as yet found no specific, and each case is to the doctor more or less difficult to control.

First a definition. What is leucorrhœa in unmarried women and girls? I reply, a discharge from the vulva, which may be viscid or ropy, white or yellow, offensive or bland, depending for its characteristic upon the part of the mucous membrane which is suffering from disease. In all healthy women

there is a mucous secretion in the vagina which lubricates the parts. There is also a slight mucous discharge from the os-riteria, and the glands of the vulva are normally frequently active to prevent discomfort. We call this discharge *leucorrhœa*, and treatment is demanded only when it is sufficiently excessive to cause discomfort to the individual, and soil the linen.

Thomas, afraid of having any one consider leucorrhœa as a disease *per se*, hesitates, he says, to devote even a separate chapter to this affection; and Emmett only notices it as a symptom of various abnormal conditions of the uterus and its appendages.

The history of leucorrhœa dates back to the very earliest writings of Greek, Roman, and Arabian physicians, and it is to-day as great a trial as it was in "ye olden time." Many attempts have been made by local and internal medications to cure it, but nine-tenths of the women who suffer from leucorrhœa suffer also many things of many physicians, each with a hobby of his or her own as to its cause, and the sufferer spends a deal of money with little if any result.

We do not hesitate to call coryza a disease; we look for its ætiology, and we talk about its sporadic, epidemic, or possibly contagious character. Ziemssen has a valuable chapter on coryza, differentiating carefully between watery, purulent, stringy, and puriform discharges, suggesting treatment for each. Why can we not discuss leucorrhœa in the same way? "Just so soon as the well-regulated balance between absorbent and secretory vessels is disturbed in the generative tract, secretion may be increased and become a source of discomfort." This excess of secretion is a horror to the sufferer. How shall we relieve her? Doctors disagree on this point as on many others, one class asserting that internal medication affecting the blood and so regulating the nourishment of the part will heal the diseased condition of the mucous membranes of the generative organs, as readily as medicine will cure diseased conditions of the

nose and fauces. Others recognize the douche and atomizer to be at least valuable adjuncts in the medication of the nares and fauces ; inhalation of vaporized drugs indispensable, in treating successfully diseases of the lungs and bronchi, and these also affirm it to be utterly impossible, however carefully the remedy may be selected, to cure leucorrhœa without topical application of drugs to vagina, or uterus. To this latter *credo* I own allegiance until experience proves it like the first mentioned—fallible.

The causes of this disease are constitutional. A scrofulous, tubercular dyscrasia, as it inclines to abnormal activity of the glands in different parts of the body, naturally does not spare those of the genitalia in women. And for leucorrhœa so resulting one must necessarily have recourse to constitutional remedies, treating the diseased membrane and glands of the genital tract exactly as we would if the malady had attacked the lungs or throat. Chlorosis is another cause of leucorrhœa, and one must necessarily have recourse to iron and arsenica as constitutional remedies. Among very young girls, especially of the better class of children, leucorrhœa is not uncommon. It has been the habit of many physicians to refer it to the presence of ascarides which travel from the rectum, but in my judgment this trouble is really a species of vulvitis and catarrh, and may be brought on by various imprudences, among which may be counted the sitting on the ground or on stone steps, often with only but a little bit of fine linen between the child's body and the earth, and a game of *jack-stones*, the delight of most little children, may make one an invalid. We may also blame overheated school-rooms, badly arranged seats before the desks, and irregularity in attending to the calls of nature in regard to the evacuation of bowels and bladder ; in brief all disturbances of circulation in the pelvis of little girls are potent causes of leucorrhœa.

After puberty the active congestion of the menstrual period rapidly passes into an acute inflammation from expo-



sure to cold. Just before the flow begins there is a heightened nervous sensibility, and the whole nervous organism sympathizes, so that draft on the back, or a chill in the feet, or a sudden shock of trouble, annoyance or grief may cause endometritis, while at any other period of the month such result would not ensue. After the acute inflammation subsides the natural result is a viscid, ropy secretion from the Nabothian follicles, and as it passes through the vagina out upon the vulva it may cause irritation in its way.

Perhaps I am flying in the face of prejudice when I attack the "water-cure" system, which, in my judgment, has done fully as much as any other so-called system of therapeutics to injure the constitution of the women of to-day. Its advocates claim to appeal to the reason of women that no part of the body should be left unclean, if by any chance water can reach it, and mothers are urged to train their daughters to the use of sitz-baths and vaginal injections, so soon as they reach the age of puberty. In nine cases out of ten of the well-bred girls who apply to me to heal leucorrhœa, in answer to the question, "Have you ever used injections?" "Do you take cold sitz-baths?" they say, "Only when I stop menstruation, of course. I must be careful to do it then." How do they know just when they have stopped menstruating? It is the habit of the uterus, in some persons, to discharge a little of the blood and then have a sort of rest from its labors, for a few hours, when the flow begins again to continue perhaps another day or two. The girl, not noticing any discharge on the napkin, and eager to be clean, hastens to take a sitz-bath, and injection of cold water. She may do this with impunity for months in succession, but eventually nature demands the penalty. A time comes when, from no cause which she recognizes, the "flow" is delayed, then it does not pass as freely, and there may be a little more pain. Soon the girl notices a discharge gradually increasing in quantity until the patient is not free at any time from leucorrhœa, which often is allowed to con-

tinue for a year or two, as it has in several cases in my experience before a physician was consulted. The discharge often is perfectly bland, unirritating, but so excessive as to need protection for the clothing.

The mucous membrane of the uterus, and in fact of the organs surrounding it, during the menstrual period are hyperæmic, hypersensitive, and the shock of cold water causes naturally a congestion, then decay of the cells, and the resultant discharge, which consists of "white corpuscles, mucous corpuscles, and epithelium, and a large number of those little structures called micrococci covering the cells." Leucorrhœa from this cause I have found exceedingly difficult to cure, for the reason that the membranes have formed the habit of excessive cell proliferation, and it is difficult to tone them up sufficiently in the short time that a patient will usually give the doctor to manage the case.

In the vagina, like the rectum, is a self-cleansing passage and it is protected by the hymen. There is no reason for an attempt to introduce any washes except in cases of disease, and the healthiest women, probably, have never even heard of a syringe. As soon would it be necessary to cleanse the œsophagus by irrigating it with cold water, after each meal, as to cleanse the vagina after each monthly period. Injections should never be used by any person except when ordered by a physician for diseased conditions which he recognizes. So uniform has the injurious habit of taking injections become, that in two elegant houses in Chicago, in the bath-room, I have found sitz-bath tubs and right in the center a tube coming up. I inquired, "What is that for? why do you have so many faucets?" "Why, this little faucet is to use for injections," to fit the tube on. Imagine the force with which the water will enter the body of the poor mortal, with the pressure from the top of the tower of the water-works!

Again, posture is a potent cause of leucorrhœa. The standing or sitting too long causes a flow of blood to the

pelvis, and because of the presense of an excessive quantity of blood, there is necessarily subacute inflammation and leucorrhœa, a strong argument in favor of seats in shops where girls are employed. Another point in reference to leucorrhœa which I would like to have the opinion of specialists upon is as to the metastasis of catarrh. It really appears to me that my patients alternate between catarrh of the nares, and catarrh of the uterus and vagina. "I feel so much better this week, so far as my head is concerned, but the leucorrhœa is very troublesome," is a statement that I hear often in my practice. Appealing some three or four years ago to a celebrated gynæcologist, he sneered at the suggestion because there was no continuity between the mucous membrane of the uterus and the tubes, and that of all the rest of the body. "How then," said he, "can the disease pass from one point to another?" My reply would be, that it was through the close relation of the nervous system, notably the sympathetic. One cannot touch one extremity of the human organism without having the knowledge of that touch reported in every part of the system. Disease cannot invade one part which is presided over by a certain series of nerves, as those supplying the mucous membrane, without having disease communicated through that set of nerves to the other part; and so it seems to me that by this close relation of the uterus and the other parts of the body through the sympathetic, we may account for the metastasis of the disease. However this may be, of the fact I am assured, the glands of the cervix uteri will be enlarged, swollen, and discharge when the glands of the throat are in their normal condition, and *vice versa*. And when one recognizes a fact of this kind it seems folly, and worse than folly, to refuse to act upon it because there is "no continuity between the parts."

Homœopathic materia medica seems to me peculiarly rich in remedies which meet this condition, and for such cases as these I am always glad to prescribe according to the

totality of the symptoms. With the iodides, those of mercurius and of calcareæ, with silicea, hepar sulph. and kindred remedies, one feels armed to meet such a condition, at least so far as to relieve the temporary engorgement. Whether or not leucorrhœa from *constitutional* causes can be cured, seems to me exceedingly doubtful. The abortive treatment should be begun in childhood when the mother recognizes the constitutional tendencies of the child. In view of this one must feel very anxious for a wider education of the women who must be mothers, not only that they may wisely preserve their own life, but that they may recognize hereditary taints and weaknesses and seek medical advice in time to abort the evils which threaten the children.

The treatment of the diseased vagina or uterus in virgins should in my judgment consist, so far as practicable, aside from remedies, in applications which can be made by the patient herself. I confess to an earnest adherence to the old-fashioned idea of the sanctity of the hymen. Except that the opening allows the flow of menstrual blood, its purpose can be but one—preserving the chastity of the woman, and no local treatment, no digital or ocular examination should be made of the *virginal genitalia* until all other means are exhausted. It may be, it often is absolutely necessary, but let that be a *dernier ressort*.

For leucorrhœa from debility, as of chlorotic girls of lymphatic constitution, I have in several instances used successfully the following prescription :

R. Salicylic Acid.....	6 grammes.
Glycerine.....	100 grammes.

Dissolve over water-bath, add one litre of water. Make up six injections thereof, using one a day.

Then too, I like alcohol and water, *Pinus Canadensis*, glycophtenique, hydrastis, permanganate of potassa, quinia, sage tea, listerine,—depending upon symptoms for my choice of drug to be used as injection.

Suppositories, etc., are useful in the hands of the patient,

and Hale's Geranium Compound has done well in my hands. Of course nearly all the remedies enumerated can be made up into suppositories. When special topical treatment must be inflicted upon a maiden, each physician has in his or her own operating room applications of proven value.

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## PHYMOSIS.

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BY

GEORGE CLINTON JEFFERY, M.D.,

BROOKLYN, N.Y.

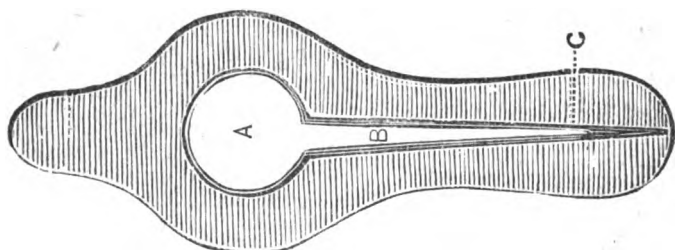
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The customary operation for the relief of phymosis has gained, from its unmodified form of performance, possibly a lasting preference in the minds of most surgeons who have performed the operation for its cure. The method of procedure now practiced and in vogue has some, if not many, advantages, and the operation being one in which the desideratum is simply to remove the existing redundancy of tissue, the operator is generally content in accomplishing that end by any plan of cutting that admits of the greatest ease and convenience to him.

There are, however, in my judgment some reasons to believe that, however simple the operation, the present method, while attaining possibly the desired result, is too crude in its plan to do credit to the surgeon who is as painstaking as the operator should always strive to be in every operation, be it great or insignificant. The danger of simply stretching the prepuce, without a guide, and then excising it haphazard, makes liable a danger which the "blade" which I shall exhibit will at all times positively prevent and make impossible, besides adding ease and assistance to the efforts of the operator.

My reference is to the cutting off of too much skin and

mucous membrane, together with the possibility of excising a part of the glans penis, which accident I once saw occur at the hands of a skillful surgeon some years since. As regards the former I have a child in the family of patients of mine, who has during the erection of the penis a condition simulating chordee, the organ being drawn to one side on account of there having been *too much* prepuce excised during an operation to which he had been subjected several years ago, the operator in this case being a surgeon whose ability and skill are conceded and unassailable, but who was obliged *to guess* where to make his excision and made—as doctors sometimes do in other cases—a very poor one.



F. Haslam & Co. Full size.

These difficulties, I need hardly add, become more probable the younger the age of the patient submitting to the operation.

The "phymosis blade," of which the above is an illustration, will, I feel, at once be appreciated by the surgeon when its advantages are explained, as I shall endeavor to do,

The child being placed upon a table, and anæsthetized, the surgeon first examines the penis and separates with a probe or some similar instrument any adhesions which may be found existing between the mucous membrane and the surfaces of the glans penis. This having been thoroughly done, the blade is intrusted to an assistant, who introduces the head of the penis through the circular aperture A; at the same time the surgeon with a pair of small dressing forceps in his left hand picks up the prepuce, which he places

slightly upon a stretch, and slides it along the groove B, until it is snugly grasped by its sides at its narrowest part. The time for the excision has now arrived ; and the surgeon, with the sweep of a sharp knife along the surface of the blade—toward C—removes generally with one incision the redundant tissue.

Some operators may prefer the scissors, which, although they do not make the excision as neatly, do so fully as thoroughly as the knife.

The operation is now completed, excepting the uniting with sutures of the skin and mucous membrane, which is done by the usual method. In the hands of the operator the "phymosis blade" will be found advantageous to prevent,—first, the possible excision of any parts of the glans penis, for the reason that the groove (B), as the prepuce is slid along it, will push it downward and underneath the blade ; second, the likelihood of too much prepuce being removed, for the reason that the sides of the groove, by the convexity of their surfaces, will hold a sufficient portion underneath and hugging the glans penis.

By a trial of the blade, the operator will, I am certain, at once appreciate the greater dexterity and neatness which by its use the operation may be performed, and thereby concede the value of the "phymosis blade" as a desirable adjuvant in the performance of the operation for the relief of this common condition.

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## A CASE OF ALBUMINURIA DURING PREGNANCY.

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BY

W. J. MARTIN, M.D.,  
PITTSBURGH, PA.

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The happy termination of a case of this grave trouble justifies the publication of the treatment employed. It is thus that we often profit by the experiences of others.

I was called Aug. 22, 1889, to Mrs. R., aged about thirty years, pregnant for the third time. No trouble of any kind in former pregnancies. Expects to be confined about the last of October. She has noticed for several weeks a progressive swelling of the feet and legs. Otherwise she feels very well,—urine copious, no thirst, no pain. Prescribed apium virus 3x trit., four powders per day. Examination of urine revealed albumen present to the extent of about one-half the volume. The patient continued to feel very comfortable, and the urine continued copious, and the swelling progressed but very slowly, until the first of October. From this time the swelling increased rapidly, so that by the twentieth of the month she was so much swollen that it was almost impossible for her to walk or sit. Urine examined at this date showed the enormous quantity of seven-eighths albumen present.

Up to the first of October there had been no change in the medical treatment, apium virus 3x four doses per day being continued right along. As this remedy seemed now to have no more influence over the case, I prescribed merc. cor. 3x trit., being influenced in my selection by the advice of Dr. R. Ludlam of Chicago, for whose opinion and advice, as well as for whose self, I have great respect.

Prof. Ludlam says, in his "Diseases of Women": "Experience has led me to place great confidence in the mercurius corrosivus. I have prescribed it very frequently to fulfill this precise indication (albuminuria in pregnancy), and it has seldom disappointed me. The idea which I design to convey is not that this, or any other remedy, is an absolute specific for ante-partum convulsibility. But if in one case out of ten you can recognize incipient symptoms of this dreadful disease and avert it, you should know how to do it."

A peculiar feature in this case was that though the urine was so very albuminous it was at no time scanty. Whether or not this was due to the medicines taken cannot be said.



On Sunday morning, Oct. 20, I was sent for: the lower limbs and the body as far as the waist were swollen tremendously,—above the waist there was no swelling. The patient felt very badly; she was sick at the stomach, had a diarrhœa, and was distressed by pains extending from the back around to the groins, and a frequent desire to urinate, with discharge of but a small quantity each time. I prescribed *nux vom.* 3, and instructed her to send for me if labor set in, which I felt was very probable. At eight o'clock in the evening I was called. The pains were frequent and strong. On attempting to make an examination I met with a serious obstacle in the immensely swollen labiæ; it was with the greatest difficulty that I reached the os uteri, which was for some reason away back in the hollow of the sacrum. Introducing my index and middle fingers into the os I gently pulled it up toward the symphysis pubis, held it there through a few pains, and then withdrew my hands. After the lapse of about fifteen minutes, I made another examination and found the os again forced back into the hollow of the sacrum and no progress whatever made or making, though the pains had been strong and frequent. I again drew the os up toward the symphysis, and for one hour and a half sat by the bed and with two fingers in the os kept it from getting down into the vicious position it seemed determined to occupy. By this time the head had descended sufficiently to allow me, during a pain, to push the anterior lip of the os up behind the symphysis; then I withdrew my hand and took a rest. The pains becoming now more efficient soon expelled a vigorous and healthy child, though not without some rupture of the swollen perineum.

The amount of amniotic fluid that escaped during this labor was greater than I had ever witnessed before, not excepting cases of acephalous and hydrocephalic fœtuses, where too the amount of amniotic fluid is enormous.

This patient made an excellent recovery; urine passed

freely. On the third day I examined it for albumen, of which I failed to find a trace. A tympanitic condition of the abdomen on the second day rapidly disappeared under the influence of turpentine stupes. On the ninth day I found her suffering with a severe headache, which she said caused her to feel very hungry—she wanted to eat all the time. This kind of headache I had on several occasions cured with psorinum; I gave her a few doses of the psorinum 30, with the happiest results. The œdema is disappearing rapidly, so that now, the thirteenth day after delivery, she is up and moving about the room, feeling very well. Visits discontinued.

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### SOME THOUGHTS ON THE DIAGNOSIS OF PREGNANCY.

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BY

SHELDON LEAVITT, M.D.,  
CHICAGO, ILL.

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In the July number of this journal is an article by Lamson Allen, M.D., on "The Uncertainties of the Signs of Pregnancy," which has attracted my attention, and has induced me to offer a few observations, not so much in criticism of that article as of review of the various relative and certain signs of the condition in question. I agree with Dr. Allen that it is many times exceedingly difficult, especially in the early weeks of gestation, to offer anything like an unqualified opinion concerning the condition; yet I think by applying certain tests, and by studying the more reliable symptoms and combining them, we may, in nearly all cases, arrive at a satisfactory conclusion. I do not profess to be infallible, but I may be pardoned the suggestion that many practitioners give too much attention to some signs, while they fail to give due weight to certain others which are much more diagnostic in character.

In order to avoid the appearance of anything like a systematic and thorough consideration of the subject at this time, I will take up the case cited by Dr. Allen, in which he found so much difficulty in diagnosis, and follow it along, as he does, to the happy termination. This was evidently a case wherein there had been left considerable subinvolution of the uterus after former labors, and it was this condition, together with complications which so often grow out of it, which rendered the case peculiarly difficult. The two circumstances which contributed most largely to the condition of subinvolution were early rising after confinement, and laceration of the cervix uteri. When first seen by Dr. Allen after indications of pregnancy had arisen, she was, as subsequent events clearly prove, about two months advanced. At that stage of pregnancy the changes are so slight that, as a rule, little can be determined with confidence; but in this instance two or three of the more important signs were found, namely: (1) absence of the menses, (2) a softened ("flabby") condition of the os, and (3) an enlarged stage of the uterus. To be sure all but the first symptom *may* have been present for weeks or months; yet now the addition of the first ought to have been regarded at least with great suspicion. Instead of so regarding it, Dr. Allen proceeds to treat the patient faithfully for "metritis and laceration of the os." It has been my fortune to encounter a number of cases wherein physicians have proceeded with similar treatment for similar conditions, assuring the patient that no pregnancy existed; but which in every instance was successful in bringing about a miscarriage. During all this time, and in fact throughout gestation, did Dr. Allen continue his treatment, which, he says, was "successful." Up to the close of the sixth month, he informs us, the growth of the uterus was not at all commensurate with the age of the foetus; but whether it was remarkably rapid from that time forward, he does not state; and yet he adds that, on March 29, she was delivered of a healthy child. I cannot

wholly reconcile these statements, since the phenomena, as thus represented, are entirely different from anything which has fallen under my notice.

We are then told that "a review of this case will show that there was not, up to the last of the sixth month of pregnancy, a single definite symptom of the fact thereof. To be sure, menstruation had ceased, and the os uteri was soft, but it was the softness of ulcerated and œdematous tissue. There was an absence of all the common signs, namely: of morning sickness, ballottement, uterine souffle and foetal heart sounds, the violet hue of the vagina, the discoloration of the areola of the nipples, softening of the vaginal cervix, and the usual changes in the growth of the uterus, and active foetal movements till late in pregnancy."

To be sure, we often get a certain amount of softness of the os uteri arising from a diseased condition of the part; but I think the doctor, in this case, was not justified in attributing the softness which he found to ulceration and œdema. There may have been absence of many of the common signs of pregnancy; yet enough of the more important ones were present to justify him in giving, with little qualification, a diagnosis of pregnancy long before the sixth month. What deserved more weight than any other symptom was the progressive enlargement of the uterus which must have been present. In any case, we should attach more significance by far to this than any other one symptom.

On our first examination, in the early weeks, we may not feel sure whether the enlarged condition of the uterus is recent or ancient; but with absence of menstruation, softness of the os uteri, and progressive enlargement of the uterus, even though other common signs are absent, we may very confidently regard the condition one of pregnancy. It is through neglect either to consult this sign, or properly to esteem it, which, in my opinion, has so often led practitioners into error. Not long since a prominent physician

in my own city had under his care a woman who was supposed by him to be in gestation, but who finally passed over what was thought to be full term without any indication of approaching labor. On account of the anxiety manifested by the patient and her friends, counsel was called, who, upon making an examination, was able to determine at once that the uterus remained comparatively small; and turning to the attending physician, in vigorous language he most properly expressed his estimate of the latter's powers of diagnosis. Such errors are inexcusable.

In my lectures to students I always take particular pains to instruct them to give much greater weight to the testimony offered by the uterus itself than to any which may be elicited from reflex symptoms; and this is the thought which I desire to emphasize in the present communication.

I collect from one or two short paragraphs in Dr. Allen's article that he attaches great theoretical value to the sound as a means of diagnosis in such cases, though, of course, he looks upon its use under such circumstances as impracticable. My own opinion is that little more *could* be determined in those cases by resort to the sound, even if we had the temerity to use it, than can readily be learned by conjoint touch. If the uterus is enlarged, we can so determine without the aid of the sound.

In the latter part of his article the doctor requests an expression from the members of the society to which this paper was submitted concerning the frequency of cases which present the sign of softening of the vaginal portion of the cervix. I do not know what response this inquiry elicited, but I have yet to see the case of pregnancy, advanced beyond the second or third month, wherein softening of the cervix was not present throughout the os, and for a little distance into the cervical tissues.

Of course it is impossible for one to judge accurately of the difficulties attending a case which he has not seen, and I might have fallen into the same error as this worthy prac-

tioner, had this woman come to me for examination. While I have indulged in some criticism it has all been kindly meant, and is given precisely as it would have been had I been fortunate enough to be present at the meeting of the society which was favored with its reading.

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## A POINT REGARDING THE DIET OF PREGNANCY.\*

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BY

HENRY G. HANCHETT, M.D.,

NEW YORK.

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I fear that I shall not be able to lay before my colleagues of this Society anything very new or strange in the present paper, chiefly because my obstetrical experience has been monotonously commonplace. I have been fairly well satisfied with the amount of this kind of work that has fallen to my lot, and the only trouble I ever had was in the case of a woman who had lived out full half of her allotted three-score years and ten in a state of single-blessedness, and then married and became pregnant. She was a woman of fairly good health and physique; still during the latter months of gestation I dosed her faithfully on caulophyllin 3d, and when she came to term she spent three days in the first stage of her labor, getting through the second and third stages in less than two hours. The only complication I ever met with was a cord of ample length encircling the neck of a baby; and my sole curiosity was the second of a pair of twins who came into the world enveloped in a caul and had to be parboiled and otherwise persuaded to undertake breathing. They named that baby after me—a fact that perhaps explains its death at six months.

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\* A paper read before the N. Y. County Homœopathic Medical Society, Nov. 14, 1889.

If there is anything more than good luck in my obstetrical record, and I never asked to give an explanation of it, I should trace it to my attention to what I judge to be a much neglected, although certainly long known, point in regard to the diet of pregnancy.

This whole subject of the physiology and pathology of alimentation and nourishment offers many yet unsolved problems. There are those who live for years and appear to be well nourished on one-tenth, or even one-twentieth of what others require in the way of food, and I have heard of one person who gained eleven pounds in weight in about eighteen hours, during which time he—for it was a man—ate nothing and drank less than three pints of water only. Still, as a general rule flesh results from food and bears a definite relation in amount to the quantity of food consumed and the weight of excrementitious matters thrown off.

Now there is no particular advantage to be derived by anybody from the birth of very large and heavy infants. It may give the mother something to brag about, but the game in that direction is hardly worth the candle. Babies who weighed at birth only one pound have matured in good health, and we all know that size and weight at birth have no relation to the same qualities at maturity. Putting this and that together would seem to argue the wisdom of restricting the amount of food to be taken by the pregnant woman; and it is possible that nature intended to give a hint in that direction by the very common experience of pregnant women with nausea and vomiting. My rule is two meals a day, and rather light meals at that, and if the patient cannot pass the third meal-time without eating, I order for it the watery fruits, like oranges, grapes, and apples, which amuse the stomach without adding any very great quantity to the pabulum in the blood.

But if flesh is of little use to a new-born babe, so is bone. Some bone he must have, as he must have some flesh, but he doesn't need as much as most babies have at birth, and the

less he has the softer and more easily mouldable his body will be, and hence the better the prospect for an easy and harmless labor for the mother. We know pretty well what bones are made from, and putting this and that together once more, would seem to argue the wisdom of relying upon the fats and albumens mainly, with such starches as are most free from earthy salts, for the diet of the pregnant woman. I order for her young and tender meats, eggs, fruits, rice, sago, tapioca, fresh vegetables and sweets, and restrict or forbid the use of bread and cereals, endeavoring also to get as pure and soft water as possible both for drinking and cooking.

But as soon as the labor is over I reverse my plan, ordering milk, bread, and grains, and endeavoring to make the milk of the mother supply to the infant those things which her blood did not furnish. This plan I believe results in easier and safer labors without injuring the child in the least.

And one other point in diet I insist upon, and that is no coffee for the pregnant woman—it undoubtedly is an irritant to the delicate nervous system of an infant, and explains much of the crying of babies. Omitting it from the mother's dietary will give her many hours that would otherwise be sacrificed to the needless fretting and crying of her child.

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## THE AFTER-COMING SHOULDER.

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BY

J. B. DUNHAM, M.D.,

WENONA, ILL.

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Possibly no accident, seemingly unimportant to patient and friends, but fraught with greatest interest to the woman in after years, so often occurs as lacerated perineum at the



time of delivery. Not for a moment presuming to offer any new mode of repairing the lacerated tissues, I would, instead, beg pardon for the possible presumption of offering a suggestion as to how such lacerations may in many instances be prevented.

My attention was directed some time since to this subject by a brief article in which the writer claimed that in vertex presentations, except occiput posterior, many cases of laceration occurred not by over-distension from expulsion of the head but by "the after-coming shoulder." This statement received special emphasis by my having recently, to my extreme annoyance, had two or three cases of laceration, that too where it was least reasonable to expect it. No operation was necessary to repair the rent, it not being deep enough in either of the cases to justify. But should it have occurred? I thought not, and felt sure it did not while the head was passing; but despite our best efforts after delivery, there it was. A possible reason for this annoying and serious occurrence having been given me, I began giving the perineum the same attention and support during the birth of the shoulders as during the passage of the head.

Clinical results have satisfied me that despite our utmost care of the perineum during the passage of the head, if we do not give it equal or greater care during the passage of the shoulder, it will by sinking deep in the tissues fairly plow its way out, in many instances, leaving, as the result, a condition that may be cured but that never redounds to our credit, and that many times causes confiding patrons to employ at their next accouchement a physician who is more careful.

## A PECULIAR CASE OF ABORTION.\*

BY

CLARA C. PLYMPTON, M.D.,  
NASHVILLE, TENN.

Mrs. T. came to me, in her first visit, looking very weak and anæmic. She said about six weeks previously she had miscarried at the third month, and was still, at times, flowing very profusely.

I found upon examination the uterus in a very decided state of subinvolution, which condition was easily accounted for by her great carelessness since her miscarriage. She had not only attended to her household duties, but also walked, rode, and been upon two or three fishing expeditions since the second week after the miscarriage. "She thought, and the doctor who saw her at the time said, everything had passed away."

I immediately compelled her to remain perfectly quiet, and put her upon such remedies as seemed indicated. During the following ten days, the flow gradually diminished, and about the tenth day a very large clot passed, with considerable pain. I did not see it, as she was in the country several miles distant.

From that time she steadily improved in general condition, and the flow ceased entirely. At the time of her next regular period it came on again, normal in every respect, and was so with the fifth and sixth month. At the seventh month, I was sent for, as she was in great pain; she showed me a little bone that had passed a few hours before. It was a femur  $\frac{3}{4}$  of an inch in length and devoid of any covering. Pain still existing, I examined and removed from the os externum and cervix, some half-dozen bones similar in size and appearance; ribs, clavicles, bones of the arm and

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\* Read before the Southern Homœopathic Medical Association.

vertebræ. There was no odor and no unfavorable symptoms. At the eighth month, a similar experience, about as many more bones having to be removed, some, especially the ribs, being so wedged in the cervix that it was quite difficult to remove them. Her health was all this time improving, not one unfavorable symptom during the intervals between the periods.

At the ninth month, there was excessive pain for a short time, and some odor for the first time. I removed this time, from just inside the external os, some four or five cranial bones, with considerable tissue covering them, and several fragments of bones from different parts of the skeleton. I have now, in almost perfect condition, seven long bones of the extremities, with clavicles, both scapulæ, fourteen ribs, two parietal bones, and what seems to be the lower portion of the occipital bone, and several fragmentary bones; all of these I removed myself at the seventh, eighth, and ninth month, of what would have been her pregnancy.

From the time the cranial bones passed, there was no more odor, no more pain; and from that time, over two years ago, she has been in her normal state of health. She had two or three miscarriages before this one—I knew nothing of them, however—and has had one living child.

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## LACERATION OF THE CERVIX UTERI.

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BY THE LATE

F. S. FULTON, M.D.

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(Continued from page 511 of Vol. II.)

*Preparatory Treatment.*—All gynecologists with scarcely any exception consider that this is essential in order to obtain a satisfactory result. Where there is the usual condition of subinvolution, hyperplasia, ectropion, cystic degeneration,

eration, erosion, leucorrhœa, and cellulitis with its attendant pain and soreness on manipulation, the patient should have hot water douches night and morning, giving at one time about one gallon of water as hot as the patient can endure. There is probably no agent which is of greater therapeutic value in treatment of uterine and pelvic inflammations than hot water used in large quantities. Its astringent action on the blood-vessels and tissues of the pelvis is very great ; so much so that where a douche has been properly given, the vaginal walls will be found thrown into many additional rugæ, narrowing the canal very perceptibly and greatly reducing the enlarged congested cervix. The proper method of giving a douche is to place the patient in bed, or on a douche board, with her hips elevated sufficiently to retain a large amount of the water in the vagina. The Davidson syringe should be used in place of the customary fountain bag, as there is a certain mechanical effect to be derived from the interrupted current of the former. Some patients are not able to tolerate the Davidson on account of the pain which the more forcible jets of water occasion. In these cases of course the fountain syringe must be used.

Having gotten the patient on the board and the bulb of the Davidson in the right hand, the nozzle, which to avoid burning the patient should be of hard rubber or glass, is inserted in the lowest angle of the vulval cleft. With the left hand the lips of the vulva should be held tightly together except at the upper angle, at which point they should gap to allow the exit of the water, thus forcing the hot water to travel over the entire vagina and subjecting every portion of the canal and cervix to its astringent action. The nozzle of the syringe should be bulbous at its extremity, with perforations on the side, but none in the center, in order to avoid the possible danger of throwing a stream into the uterine canal, which might, from the force given it, find its way into the Fallopian tubes, and through them into the abdominal cavity, exciting peritonitis, which might prove fatal.

If there should be any cysts upon the cervix, they should be punctured and their contents evacuated. It is not necessary to carefully select each cyst, but with a scarificator, of which perhaps the most convenient is figured below. The cervix may be punctured on its entire surface. This will empty the cysts and at the same time relieve the congestion by allowing some of the additional blood to escape. After this the entire cervix, and, if there is much tender-

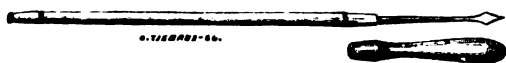


Fig. 7.

ness or congestion of the vaginal walls, they also should be painted with Churchill's tincture of iodine. Care should be exercised to introduce the iodine into the sack of any large cyst which may be punctured in order to obliterate it. The iodine will stop the bleeding and also reduce the congestion. If, as is usually the case, extensive erosions are present, iodine can be used, or a solution of hydrastis in the proportion of :

	R	Glycerine.....	$\frac{3}{4}$ ss
		Hydrastis (fl. l. ext.).....	3 j
or	R	Glycerine.....	$\frac{3}{4}$ ss
		Churchill's Iodine.....	3 j
or		Water.....	.9 parts
		Nitric acid(c. p.).....	I ..
or	R	Glycerine.....	8 parts
		Alum (pulverized).....	I ..
or	R	Glycerine.....	4 parts
		Tannic acid.....	I ..
or a creamy mixture of iodoform powder and carbolic acid. Or an application of peroxide of hydrogen.			

One of the most satisfactory medicaments for local application I have ever used is ominico, diluted about one half, and applied as a douche night and morning. It is not necessary to use a large quantity, but merely enough to thoroughly wash the cervix.

A convenient method of application is by Dr. J. A. Hawley's double-bulbed syringe, by which the cervix can be thoroughly washed without splashing or waste. Also a

favorite application of mine, particularly with raw, sore, eroded surfaces, is :

R. Glycerine.....4 parts  
 Calendula tincture.....I ..  
 Tannic acid, q. s. to make dark solution and give it some consistency.

This will be found particularly useful for soaking the tampons to be applied after treatment. Also chromic acid, in 16 or 20 gr. to the ounce, nitric acid, carbolic acid in full strength, are at times required and will yield excellent results. Argentum nitricum is best used in graded solutions, and if used properly will afford excellent results. Their strength must vary all the way from ten grains to ninety grains to the ounce. The latter will not be often required.

In the *New York Medical Journal* of October 10, 1885, Dr. B. Brown, of Alexandria, Ga., states that by the use of these graded solutions many cases even of severe lacerations can be cured. His method is as follows :

R. Arg. nit. (cryst.).... 3 ss  
 Aquæ dist.....f 3 j

Which he applies to the cervix and canal as far as the os internum. This solution he uses only in simple fissures of the cervix, without deep laceration or ectropion.

In deeper laceration he uses a solution

R. Arg. nit. (cryst.).... ʒijss.  
 Aquæ dist.....f 3 j.

With this he washes the entire surface until a uniform white coating, which consists of the albuminate of silver, is formed over the entire abraded surface of the cervix. This answers the double purpose of preventing irritation and septic infarction, and also of stimulating the formation of healthy tissue.

He uses a third solution to be applied to the cervix after the parts have healed, to reduce hypertrophy and induration, which consists of :

R. Arg. nit. (cryst.)..... 3 jss.  
 Aquæ dist.....f 3 j.

He claims that by this method of treatment the great majority of patients will afterwards recover from their sterility and bear children.

However this may be, there is no doubt but by the use of arg. nit. solutions, commencing with a solution containing 60 or 40 grains to the fʒj, and gradually reducing the strength, as the abrasion heals and the white coating becomes less, that a cervix can be properly prepared for an operation in a comparatively short time.

After all of these applications it is advisable to insert a tampon soaked in glycerine, or the glycerine and alum, or the glycerine, tannic acid, and calendula solutions. This tampon should remain *in situ* about twenty-four hours.

By its use and proper placing any displacement or eversion may be either greatly benefited or entirely relieved. The benefit of these medicated glycerine tampons lie in the watery, profuse discharge which they occasion from the parts, thereby greatly reducing the congestion and hypertrophy. It is a peculiar action which glycerine has upon parts covered with mucous membrane. If tannic acid or alum is also used, the astringent action is also obtained, which greatly increases the tonicity of the relaxed structures.

If there is a very marked degree of eversion of the lips with corresponding hyperplasia, the lips can be brought together by two silver wires introduced one on either side of the cervical canal and allowed to remain there for over two weeks previous to the operation. They should be only loosely drawn, as otherwise they will cut through. This naturally assists in reducing the hypertrophy. At the time of the operation they can be cut and removed. Dr. Goodell, of Philadelphia, says when the anterior lip is very largely increased in size over the posterior one, that it is his practice to excise a V-shaped portion from the anterior lip about three or four weeks previous to the plastic operation.

[To be Continued.]

## CHRONIC CELLULITIS, WITH COMPLICATIONS.\*

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BYD. B. WHITTIER, M.D.,  
FITCHBURG, MASS.

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I present this case, because to me it is unique in some of its manifestations, and so dissimilar to most cases of cellulitis, if such it shall be determined, that there may be great latitude of opinion regarding it. On the one hand, little concern may be excited, because of its dormant character, tending neither to resolution nor suppuration, while on the other, suspicion of malignant disease may be caused, because of its insidious development and the absence of painful symptoms, together with an unrecognized inflammation.

Lymph deposit is the consequent of pre-existing inflammation, but it is necessary to ascertain the kind of inflammation, and the tissues involved, to rightly diagnose the product. Difficult to determine as sometime are the positive causes of the deposits in the pelves of non-child-bearing women, the task is much more involved, if not hopelessly so, in unmarried women, when not associated with traumatisms. The array of causes, many of which are grossly misnamed, need not be recited, as they have little or no application to the class in which the case occurs. In cases where the deposits are of rapid accumulation, and large and dense, with the uterus and its appendages fixed, or strangulated, so that its functions become seriously impaired, or destroyed, the certainty of an active inflammation as a cause is manifest. But when the history of a case extends over a series of years, with no obtainable evidence of diseased processes ever having existed, the physician can only assume a conservative attitude in the

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\* Mass. Gyn. Society.



diagnosis of the products he discovers, and remain silent as to the primary cause. In view of such experience may there not have been some excuse for the ancient disregard for diagnosis, which we have so unsparingly condemned. The gynæcologist, be his practice longer or shorter, will have his mind stored with doubts, and his record book well filled with interrogations, and if he has not had this experience of diagnostic uncertainty, he has only attained to a limited measure of pathological and clinical inquiry.

Miss H., a farmer's daughter ; sanguine temperament, of good physique, and healthy appearance ; has had a quiet, uneventful life ; constantly a hard worker, About a year and a half ago consulted me for some indefinitely described infirmity like general debility, the symptoms and history of which made me suspicious of prolapsus uteri. A request for a vaginal examination surprised her, as the absence of the ordinary symptoms caused her to be unsuspecting of uterine trouble. No evidence of inflammation was given by examination, but a mass of indurated tissue was disclosed, a crowding down of the pelvic viscera not accountable to abdominal pressure, and a version, the exact nature of which I do not now remember. A marked feature in the case was the utter absence of pain, or sensibility.

My counsel was the local application of iodized glyceroles, with a view of discussing the mass, and internally merc. iodide 2x. Either from the attempt at a reposition, or the benefit of the application, or the mental influence arising from the determination on her part to avoid such troubles, or possibly from all combined, she was relieved temporarily. A year after, December 1888, she consulted me a second time ; her complaint was confined to the anus—itching and smarting, with a sore spot at the perineum. Deceived by the location, she supposed all uterine troubles formerly existing to have disappeared. The anal symptoms led to the fear of aggravated hæmorrhoids on the the part of the patient. An anal examination, however, disclosed neither

ulcers, fissures, piles, nor tenderness. Consequently I attributed this condition to reflex influence, as it disappeared without specific treatment. A vaginal exploration revealed the womb embedded in a large mass of indurated tissue, and pressing firmly upon the floor of the vagina. The position of the cervix uteri indicated a left lateral version, but was not verified by the sound, as the passage was obstructed at the inner os, and blood flowed without the use of force—a signal for its abandonment. Both tissue and womb devoid of sensibility, filling left half of pelvic cavity. An attempt at manipulation of the womb, or pressure on the hardened tissue, was painless. The same insensibility was apparent at the former examination.

During subsequent questioning the patient revealed the fact that at a former time the presence of a felon was unaccompanied with pain; in fact, this seemed to be a prominent characteristic of her history. Her only complaint was of extreme lassitude and inertia, with irritability and a lachrymose tendency. Attempts at reposition of the uterus were unavailing, it being "fixed." Bi-manual examination did not reveal supra-pubic extension of the mass, neither was there suggestion of a tumor. Menses normal as to time and flow, and without pain. Diagnoses deferred till further developments.

TREATMENT.—Application of iodized glyceroles. Internally merc. iod. 2x., four doses daily, with hope of restoring indurated tissue to its normal condition, and releasing the womb from its anchorage in the left ovarian region. The changes wrought in such sequelæ are either absorption, a degeneration to pelvic abscess, or an organized substance with an adventitious circulation, the latter of which will be a factor of unforeseen evil. The result to be sought in such cases is the absorption of the enfused lymph, for old as it frequently is, further time will afford it increasing opportunity to become more thoroughly organized and more than proportionately lessen the chance for recovery.

The treatment has covered five months. In first three months eight treatments were given, with the effect of lessening the pressure downward, and by the aid of uterine massage the deposit can be raised somewhat, the uterus slightly movable so that the cervix can be brought nearer its natural position, but recurs when pressure is removed.

During the last two months I added the abdomino-vaginal galvanism, and uterine massage, with evident benefit. The strength of the current was an agreeable one, of fifteen minutes duration; the positive electrode was used upon the hypogastrium, and the negative in the vagina or cervix uteri. When there is sensitiveness of the parts, in these cases the current is to be reversed. Massage was used by manipulating the mass bimanually, forcing upward and downward, or laterally when the conditions admitted, the pressure to be governed by the presence or absence of tenderness. Two weeks since I discovered a tumor in the right abdominal region, movable in all directions, extending to near the umbilicus; may be pressed into the pelvic inlet, or into the ovarian region; about three or four inches in length and two to three in width; insensible, and of uncertain form. In view of the number of treatments, there has been satisfactory improvement as regards general health, and as her complaint was of general debility with no knowledge of the tumor, she is relieved, and wishes to discontinue treatment; but in reality "the last state. . . is worse than the first." In this case results are about the only conditions demonstrable. Concerning the cause of them, there has been no obtainable history of inflammation, however insidious, as there has been no sickness that can be reasonably attributed to the pelvic organs, or, in fact, any indisposition sufficient to compel suspension of labor, save a short time when she received medication for nervous exhaustion. If we assent to the latest view that pelvic cellulitis is a misnomer, and eliminate it, we shall encounter the same questions and doubts regarding the possibility of

peritonitis as a causal factor. There is a good degree of certainty regarding the conditions discovered in a given case; but when its history is revealed, personal and medical, embracing much that is transitory and unavoidably inexact, the physician is left to rely on his own impressions quite as much as on exact data. We may be told that this unenviable attitude is the result of inexperience, lack of acumen and proper information, to which we bow a partial assent; but in return we ask *all* to concede the possibility of failure under the same test.

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## CHRONIC PERITONITIS, WITH COMPLICATIONS.

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BY

D. B. WHITTIER, M.D.,  
FITCHBURG, MASS.

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Unlike the preceding case (page 62), the history of this one gives sufficient data to determine its inception and development. Occasions of relighting of inflammatory action within the pelvis, together with other phases of ill-health, gave evidence of the continuance of disease, and its progress could be marked by periodical exacerbations. Both cases were allowed to be perpetuated, the former from the ignorance of the patient, the latter from neglect of her physician, either from inattention or ignorance. Mrs. G., aged forty-six; sanguine temperament, sallow complexion, suggestive of cachexia; enjoyed average health in childhood; menstruated at fourteen; was regular, excepting a few months, during which she experienced ill-health. No further interruption in the return till the age of thirty-six; since which time the periods have been anticipated from three to six days. At the age of forty-three a pro-

tracted menstruation of fifteen days occurred, followed by a suspension of ten weeks. At twenty-two, when tossing a heavy child, experienced a sudden sensation as if something had given away in the abdomen, followed by cramping pains, of short duration, but recurring at long intervals for a year. Soon after contracted a severe cold, which was located in the hypogastrium; suffered most intensely and was confined in bed for three weeks, when she convalesced. Has never enjoyed her previous degree of health. Physician pronounced the disease a uterine trouble.

Since a return to apparent health her discomfort has been that of nervous exhaustion. Married at twenty-four, though desired, no children have blessed their union. About the age of forty she began to have severe pre-menstrual headaches, often accompanied with nausea and vomiting, with catchy pains through right hip at intervals, which often confined her to the bed for several days. Was relieved from this condition by family physician. Subsequently treated for nervous prostration. The amelioration being only temporary, the physician was induced to make an examination, which disclosed a displacement and cervicitis: was somewhat relieved by local treatment. Soon after, by manipulation, she discovered a hardened mass in the hypogastrium. The attention of the physician being called to it, he pronounced it a tumor, and advised non-interference, unless it should trouble her. Little attention has been given her case since. For only a comparatively small portion of her life has she been incapacitated from attendance to household duties. Besides, she has performed public work. By use of hygienic measures has kept herself from being regarded as an invalid, though far from possessing good health. A buoyant spirit, and a clear conscience, have saved her from despondency. Through all the vicissitudes of years, the nature and cause of her ailments have not been properly understood,—the lot frequently of non-child-bearing women.

An adequate idea of this case cannot be conveyed by this historical sketch, nor, I fear, by any pathological picture that may be attempted. It is so gratifying, in the midst of this medical fog, to be reassured of a reputation, that I insert this paragraph from the patient's own recital of her history: "After passing through all this with so little benefit, she concluded to consult Dr. Whittier, of Fitchburg, a physician of well-known skill and ability." This lady came under my care last March. I found upon external examination a hardened mass extending from the pubic arch and groins nearly to the umbilicus; the upper border well defined, of irregular shape, quite firmly adherent to the abdominal wall, and somewhat tender, presenting evidence of sequelæ of peritoneal inflammation. A vaginal exploration revealed a sharply anteflexed uterus, firmly embedded in a diffused lymph deposit, embracing the peri-uterine connective tissue completely filling the pelvic inlet; endocervicitis, and enlarged cervix from hyperplasia. On right side, a substance hard and sensitive, which to my mind had acquired an adventitious circulation, or from extension of morbid action absorbed some of the adjacent pelvic arteries. If indeed it was a separate growth, the dimensions could not be determined, owing to its coalescence with the deposit on the right side. By vaginal touch it indicated great vascularity, arterial pulsation being a marked symptom. The treatment pursued in this case was similar to the preceding one, except that arsenicum iodide 2x. was given internally, and vaginal irrigations of hot water were used. The douche was the interrupted current, and acts as a mild massage, and aids in promoting absorption. Twelve treatments have been given, resulting in better general health, a loosening of the attachments of the indurated mass, which by bimanual manipulation is considerably mobile. Little perceptible change is indicated in the suspected neoplasm in the right side of the pelvic cavity. The vascularity re-

mains unchanged, and the pain and tenderness, which were at first general, are now confined to this substance.

The meager results shown in attempts to cure such residual products of disease of such age and severity, evince beyond question the necessity for the clearing up of these tissue thickenings in the acute stage, for at this period their discovery ought to be made, if they exist. A great responsibility is thus imposed upon the physician, which he cannot dodge. Neglect is culpable,—it is medical defeat as well. Physicians are likely to congratulate themselves upon a cure when only pain and fever have subsided. Remnants of disease may be left uncared for, and possibly unknown. In the chronic stage, indolent though the action seem, recurring inflammation increases the bulk and density, and enhances the danger of degeneration to abscess, or some organized substance. The dire effects of these upon the genital organs of women are numerous and appalling, making life a burden by remaining life-companions of their victims. Among other serious consequences it should be remembered that a fixed uterus is in all probability a sterile one. Women endure quite enough of adverse conditions as their lot, with a commendable benignity and fortitude, the equal of which would be a severe test of the courage and endurance of men, without the imposition of nervous and physical wrecking from diseases unrecognized or neglected. The diagnosis and prognosis of these cases I refrained from naming in the beginning, that there might be a chance for doubts to enter your mind, as they did into mine, and that you, like me, might wrestle with the problems which they present. The data for favorable prognosis were not reassuring, since much valuable time and pains-taking treatment are required to reconstruct the tissues and absorb the remnants of disease of this kind, if it is possible to accomplish either.

Many physicians and patients alike, I am aware, are seldom willing to give the prolonged treatment and study

requisite for recovery from these conditions, but the physician should not be a party to their concealment, or fail to impress the patient with the necessity for their cure.

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### PELVIC ABSCESS.\*

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BY

ROBERT HALL, M. D.,

PROVIDENCE, R. I.

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Mrs. T., twenty-two years old, married four years, light complexioned, blonde hair, nervous temperament, and has a scrofulous diathesis; catamenia commenced at fourteen; menstruation painful at the beginning for three or four hours, otherwise quite normal. She has suffered from synovitis of the knee-joint, which commenced at the age of fifteen. Five months after marriage she aborted at the end of the second month of gestation. July 8, 1887, she was taken with peritonitis, from which she recovered in about six weeks. November 27 of the same year, she says she had a second attack similar to that of July 8, which was followed by pleuritis of the right side, and lasted twelve weeks. On March 6, 1888, she had the third attack of peritonitis, from which she recovered in about five weeks. On June 9, she sailed for Europe, and soon after arriving in Switzerland was confined for about two weeks with pain in the abdomen, after which recovery she remained quite well (with the exception of soreness and pain for about a week previous to menstruation) while in Europe. She arrived home in Providence the first of last October. She called at my office two or three days after her arrival, and expressed herself as feeling very well.

I will state here that I saw her only in the first attack;

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\*Read before the Boston Gynecological Club.



and in that after the first five or six days had passed. When I saw her she was lying on the back, the legs partially drawn up; face indicating severe distress, although largely under the effects of opium. The pulse about 130 and small; abdomen distended and very sensitive to touch. Nausea was almost constant, and vomiting quite frequent; bowels inactive. The pain was intense, and extended all over the abdomen. At the time of the present attack she was at the seaside. After sitting under the veranda for some time in the evening, during a fresh breeze from the water, she experienced a chill, and then resulted the above condition.

On October 8 I was called to see the patient again. Then she was complaining of severe pain in the epigastrium, and extending into the right side of the chest. The pulse was about 120, temperature  $103^{\circ}$  in axilla, the locality of pain very tender to the touch. After about two days the pain and soreness extended to the right inguinal region, at the same time receding from the previous locality. Here, after two or three days, a tumor was detected above Poupart's ligament, about the size of the fist. This could also be felt per vaginam high up at the right of the uterus. About the tenth day of the inflammation a sensation of something snapping was felt (as the patient described it), and soon the pain was relieved. About twenty-four hours from this time a dejection from the bowels took place, which contained a quantity of pus. The patient experienced frequent rigors during the formation of the abscess. After this for about three weeks, once in about three days, an exacerbation of pain would take place, lasting from twelve to twenty-four hours, after which pus would reappear in the stool.

After this the patient made quite a rapid recovery, and sailed for Europe again January 5, 1889.

TREATMENT.—Hot fomentation to the abdomen; hot

vaginal douches, quiet room, well ventilated, and during convalescence a nourishing diet, champagne, etc.

*Remedies.*—Aconite, merc., and hepar sulph. Sulph. morphia subcutaneously, and in suppositories, was used in sufficient quantity to relieve the severity of the pain.

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### DE BAUN'S OBSTETRICAL ROPES AND HANDLES.

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BY  
EDWIN DE BAUN, M.D.  
PASSAIC, N. J.

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It is a fact, that with but very few exceptions, during the second stage of labor women require something to pull



CUT REPRESENTING INSTRUMENT IN PARTS.

on. It may be the physician's or assistant's hands, a sheet fastened to the bed, or some other contrivance, all of which

have proven unsatisfactory to me, and therefore I have devised the use of the ropes and handles, the mechanism of which the accompanying cuts will in part explain.

I have used these ropes and handles in many cases of confinements, and they have given great satisfaction both to my patients and myself. Although the use of these do not hasten labor, yet they give such ease to the patient that one is fully warranted in adopting them.

Since this apparatus has gained publicity, many of my patients request that I bring it with me.

The rope is one piece, and runs through the two holes in



CUT REPRESENTING PATIENT LYING ON HER BACK USING THE HANDLES.

the end of the clamp in such a manner that as soon as tension is made the rope fastens itself in the clamp and cannot be pulled either way. By means of the two loops in each handle the ropes can be shortened or lengthened to suit the patient.

The clamp is attached to the foot-board of the bed at the most convenient side; the rope is then slipped through the holes in the clamp so as to bring the shorter rope to the side of the bed on which the patient lies; the other end of

the rope is then thrown around the opposite side of the bed; now the handles are adjusted to the proper length for the patient, and the instrument is ready for use, this adjustment requiring but a moment.

The special advantages which I claim for this instrument are: The ropes being so fastened to the bed, the patient can lie on her back or either side, or she may change to any position on the bed, and still grasp both the handles; she can pull much more evenly than by taking an assistant's



CUT REPRESENTING PATIENT LYING ON HER SIDE AT THE SIDE OF THE BED.

hands, and is not as liable to strain herself as she otherwise might. The handles being smooth and easily grasped, she can hold them for a much longer time without fatigue to herself or an assistant; then they allow the physician to give what manual aid he may deem necessary during the pains, especially at the close of the second stage, without being hampered by the patient's movements in the often wild desire to grasp something. The handles being on each side of the patient, do not in any way embarrass the progress of labor, and less assistants are necessary at the bedside. All patients using them, especially if the progress of

labor be of long duration, are less fatigued and notably in a much more cheerful frame of mind.

Taking up very little room, they are very light to carry, and are easily and rapidly adjusted to any bed.

Understand, I do not claim that these ropes and handles hasten labor in any way; nor do I claim for them anything other than the comfort and convenience they afford both the patient and the physician.

Of the sixty-four cases in which I have used these handles I cannot recall one instance in which any trouble could be attributed to the use of the same, nor have I heard of any patient feeling lame or bruised.

Of course the disadvantages of the old plan are obvious, although having been practiced for a long time; but I think the points in favor of this apparatus may be accepted, but, should only a FEW adopt MY plan, I shall feel fully repaid for my exertions.

W. F. Ford, of Hazard, Hazard & Co., of New York City, has faithfully carried out my ideas.

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## INSANITY OF PREGNANCY AND ITS MEDICO-LEGAL RELATIONSHIPS.

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BY

H. H. CRIPPEN, M.D.

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I have in previous articles referred incidentally to some medico-legal questions that require fuller explanation. Not that I advise the attending physician to take any responsibility whatever. Quite the contrary; for even experts on insanity sometimes appear to little advantage in the courtroom. Be the medical adviser, if necessary to send your patient to the asylum, but never take any legal responsibility,

nor even interest yourself in the initiatory steps toward controlling the patient. You will receive few thanks, and, the chances are, much blame for stepping outside the simple duty of signing your patient's certificate of commitment to the asylum.

There are certain cases that are of interest in connection with our subject, and first among them are those of women who have been seduced. In such cases there exists a motive for crime, the inducement to hide or destroy the proofs of their disgrace by concealment of the evidences of birth through destruction of the child; but aside from this there may be a brief frenzy produced by the violence of the labor pains: often there is delirium of short duration appearing a few days after birth, or there may be a mania transitoria appearing at the onset of the milk. In any of these conditions, with a flushed face, a full quick pulse, and active talkative delirium, the patient may, as a result of hallucinations or morbid impulses, destroy her child or wildly endeavor to injure herself or others. The court will rarely hold any woman guilty under such circumstances. Here we have the distinguishing testimony that such patients rarely try to hide the evidence of their crime, and no memory of their action is retained.

Several cases of homicidal insanity in women, connected with pregnancy, parturition or lactation, have been reported Beck\* cites the case of a pregnant woman, who murdered her two children. In this case several of her relatives had become insane. The medical examiners decided that the woman suffered from a momentary aberration of the mental faculties, but she was condemned to six months imprisonment. Manifestly a wrong sentence, but this was during the time of Esquirol, when the legal rights of insane persons were not so carefully guarded as now.

In another case, a female was guilty of many acts of theft. She was fifty years of age, of excellent character and easy

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\* "Medical Jurisprudence," vol. i. p. 819.

circumstances. On arriving at Paris she committed numerous larcenies at shops. Esquirol and Marcé, to whom the case was referred, reported in favor of her being affected by monomania. She had previously been subject to puerperal mania.

Esquirol\* met with several cases of morbid objective impulses, among them that of Madam N., whom he had under his charge in the hospital (La Salpêtrière) and whom he describes as being perfectly rational in her conversation and conduct, and of a mild, affable, and industrious disposition. She very calmly related to him the circumstances connected with a strong inclination she felt to kill her child.

"After her last accouchement, fourteen months before, she had several hysterical fits, and was much troubled with pain in the head, stomach, and bowels; with vertigo, and ringing in the ears. These mostly disappeared, but she then became exceedingly capricious in her temper and affections, being alternately gay and sad, confiding and jealous, resolute and weak. In this condition, she heard of the murder committed by Henriette Cornier, when she was immediately seized with the idea of killing her infant, and one day when her child entered the room, she felt the most violent desire to assassinate it. 'I repelled the idea,' said she, 'and coolly inquired of myself, why I should conceive such cruel designs—what could put them into my imagination? I could find no answer. The same desire returned; I feebly resisted it, was overcome, and proceeded to consummate the crime. A new effort arrested by steps, I raised the knife to my own throat, saying to myself, better perish yourself, bad woman.' When asked the cause of these evil thoughts, she replied, that something behind her back urged her on. During the first fortnight of her stay in the hospital, she was afflicted by a return of the physical disturbances with which she was at first attacked, but at the end of six weeks was so much better, in consequence of a

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\* "Des Maladies Mentales," Paris, 1838, tome ii. p. 321.

proper medical treatment, that she received her husband and child with joy, and lavished on the latter the tenderest caresses. Suddenly she perceived a cutting instrument, and was seized with the desire of snatching it up and committing two murders at once,—a thought which she suppressed only by flying from the room. The symptoms of physical disturbance now again made their appearance, during which she was informed that her child was sick, and while extremely distressed and weeping at the news, she felt a violent desire, to use her own expression, 'to stab or stifle it in her arms.' After about three months' residence at the hospital, she went away restored and continued well."

Dr. Barbier of Amiens relates a similar case. "This lady, Marguerite Molliens, twenty-four years old, had suffered, for three years past, pains in the epigastrium, and right side of the abdomen; headache, vertigo, noise in the ears, disturbance of vision, palpitation of the heart, constrictions of the throat, and trembling of the limbs. Her first child, which lived but three months, she loved and deeply regretted. Nine months ago she had another child. On the fifth day of her confinement she heard of Cornier's case, and was so deeply impressed with the story, that her thoughts dwelt upon it, and from that moment she feared lest she also might be similarly tempted. In spite of her efforts, she gradually familiarized herself with the idea of killing her child. One day while dressing it, the thought of murdering it seized upon her mind and became a violent desire. She turned around, and perceiving a kitchen-knife on a table near her, her arm was involuntarily carried towards it. She saw that she could no longer control herself, and cried out for assistance. The neighbors came in and she soon became calm. Shortly after she was separated from her child and sent to a hospital, where she finally recovered. It is worthy of note that when the pains in the head and epigastrium, from which she suffered greatly in



the hospital, were worst, then the bad thoughts appeared to be most imperious."\*

Ray gives a number of very interesting cases that are worthy of brief mention. The first is related by Dr. Otto of Copenhagen. "A female who was received into the lying-in hospital of which he was physician, requested a private conference with him previous to her accouchement. She appeared to be in great agitation and embarrassment, and begged of him that she might not be left in the same chamber with other women and their infants, as it would be utterly impossible for her to resist the propensity she felt to destroy the latter. Her request was granted and she was carefully watched. Her delivery was easy and the child was kept from her and afterwards sent to her mother. The young woman, on leaving the hospital, went into service, and would not return to her mother's, lest she should be tempted to destroy her infant. She declared the sight of a very young infant kindled up a violent propensity to destroy its life. This woman was a peasant who had been seduced, but had never led a dissolute life, nor was in any way of corrupt manners. She had not been reproached, nor ill treated by her parents, during pregnancy, nor was there the least cause for anxiety on account of the child, as her mother had engaged to provide for it. She entered into the service of a clergyman, and enjoyed good health. Some time afterwards she informed the doctor that she had lost nearly all propensity to infanticide."

The next case is recorded by Dr. Michu. "A country woman, twenty-four years of age, of a bilious, sanguine temperament, of simple and regular habits, but reserved and sullen manners, had been ten days confined with her first child, when suddenly, having her eyes fixed upon it, she was seized with the desire of strangling it. This idea made her shudder; she carried the infant to its cradle, and went

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\* "Medical Jurisprudence of Insanity," Ray, p. 232.

out in order to get rid of so horrid a thought. The cries of the little being who required nourishment, recalled her to the house ; she experienced still more strongly the impulse to destroy it. She hastened away again haunted by the dread of committing a crime so horrible ; she raised her eyes to heaven, went to the church and prayed. The whole day was passed by this unhappy mother in a constant struggle between the desire of taking away the life of her infant and the dread of yielding to the impulse. She concealed her agitation until evening, when her confessor, a respectable old man, was the first to receive her confidence. He soothed her feelings, and counseled her to have medical assistance. 'When we arrived at her house,' says Michu, 'she appeared gloomy and depressed, and ashamed of her situation.' Being reminded of the tenderness due from a mother to her child, she replied : 'I know how much a mother ought to love her child ; but if I do not love mine, it does not depend upon me.' She soon after recovered, the infant, in the mean time, having been removed from her sight."

Ray's third case is related by Lord Hale. "In 1868, at Aylesbury, a married woman of good reputation, being delivered of a child, and not having slept many nights, fell into a temporary phrensy and killed her infant in the absence of any company, but company coming in, she told them she had killed her infant and there it lay ; she was brought to jail presently, but wondered how or why she came thither ; she was indicted for murder, but the jury found her not guilty, to the satisfaction of all who heard it."

One more case given by this author is worthy of note.

"Martha Prior, wife of a laboring man, showing symptoms of mania, soon after delivery, her physician ordered her to be watched, and not allowed to have the child. On the thirteenth day after delivery, while her attendants were out of the way, she ordered her little daughter to bring her the child, and soon after a razor, saying she wanted to cut

the hard skin from her hands. She instantly cut off the child's head. To those who first came in, she seemed calm and collected, said it was what she, all along, had been intending to do; and added, that she would not care if any one served her the same. Her mind had previously been quite unsteady. She often said, she knew she was going to die, and was certain she was going to hell. She had borne a good character."

There is still another class of cases of peculiar character which require careful attention from the jurist, that is those cases in which labor occurs in an insane woman without her knowledge.

The insane when delivered are often free from pain, and several cases are on record in which the cry of the child was the first intimation that labor had occurred. The insane parturient woman may thus suffer from anæsthesia, so that, being weak-minded, the child may be smothered in her bed, and she can yet truthfully say that she did not know of its birth. Berthier, of Lyons, cites a case of melancholia during pregnancy in which abortion occurred without the knowledge of the mother. Dr. G. H. Savage gives a case in which he saw a woman with a fully developed child in the bed, the mother having been delivered without any evidence of pain, so that, although there were neighbors in the same house, the delivery took place without their knowing it; the mother, herself, said that she did not know anything had happened. In such a case the child and placenta will lie undisturbed as delivered and the cord will be uncut.

So reluctant have the courts and juries become to receive pleas of insanity in defense of crime, whether the crime be due to emotional morbid objective impulse or deliberately planned and executed by a mind in which no derangement of the intellect has ever before been perceived, that it is of the greatest importance that the nature of these cases I have recorded should not be misunderstood.

## ✿ EDITOR'S TABLE. ✿

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—With the beginning of the New Year we hoped to have something definite to rely upon in the treatment of fibroid tumors of the uterus by the chemical galvano-caustic method of Apostoli. But, concerning this subject, all is discord. At the head of our abdominal surgeons Keith and Tait lead opposing factions in a war of words ; the former representing the *Apostolic* following, and the latter the purely surgical view. Keith, on the one hand, predicts a wonderful future for Apostoli's method ; he further says, " It may seem strange to some, that after the results I got in hysterectomy—results that almost made it justifiable—I should now begin to throw stones at the operation instead of trying still further to improve upon it ; and but for Dr. Apostoli I should now be doing so. I would give something to have back again those sixty-four women that I did hysterectomy for, that I might have a trial of Dr. Apostoli's treatment upon them." This is evidently the opinion of an unbiased operator, and carries additional weight from the fact that it is the opinion of the one who was the first to lower to a minimum the mortality that so long followed abdominal surgery, and who, by the best results yet obtained in hysterectomy, still retains that position. On the other hand, Lawson Tait takes the ground, not openly, but by insinuation, that the electrolytic treatment is a criminal proceeding by reason of delaying an operation until hysterectomy means almost certain death. But, while Lawson Tait is a master hand at argument, a careful review of the clinical lecture in which he inveighs against Apostoli's method reveals a mind which cannot but be biased by his own successes. Thus he says, " Every other English observer who has used it has already confessed that it is risky, painful, costly, troublesome, and disappointing," and furthermore he points a finger of scorn by selecting, among Englishmen, Dr. Keith as the one who " alone of all electricians can do such feats." The truth is, however, that Dr. Keith is not alone in his advocacy of Apostoli's treatment, even among English surgeons ; for, in August, 1889, a discussion

On an estimate of the value of electricity in gynæcology" formed a prominent part of the gynæcological section of the British Medical Association, and among the opinions and results elicited at that meeting there were but few who were actively opposed to this therapeutical agent. There were a few who were strong advocates of electrolysis in certain selected cases, a few who were waiting further observations and meantime were passively opposed to it, and a few who were very active and bitter in their opposition. On the whole, taking the results obtained the world over by those who are investigating this method of treating uterine fibroids, it is impossible not to conclude that Apostoli's treatment by the chemical galvano-caustic will survive even the vehement attacks of such great authorities as Lawson Tait and Francis Imlach. What is most lacking to enable us to formulate final judgment on the relative merits of electrolysis and of removal of the uterine appendages (or the uterus together with its appendages) are *facts* as to the lasting results of each method. And these facts must be of such sufficient exactness as to answer every scientific requirement that can be brought to test them. To this end we will be found among the first to open our columns to this discussion during the current year, in the hope that a series of carefully recorded cases of this mode of treatment, whether successful or unsuccessful, will do something to settle this question.

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— Our Australian medical brethren are awakening to the importance of Cæsarian section. At the meeting of the Medical Society of Victoria, Sept. 4, 1889, there was a very lively discussion on the relative merits of craniotomy and Cæsarian section, in the course of which two recent cases, from the Melbourne Women's Hospital, were reported as having had the latter operation successfully performed. We have spoken before on this subject,\* and therefore only record these successful cases to call attention to the improvement in the mortality statistics that is being brought about by experience with various methods of operating, and especially by recognizing early those cases to which the Cæsarian section is applicable.

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\* HOMOEOPATHIC JOURNAL OF OBSTETRICS, vol. xi., p. 467.

— Among the improved methods, the one which Säger terms "the conservative Cæsarian section" has met with much favor. The uterus is drawn out of the abdominal wound; the elastic ligature is then placed around the cervix, but is not tightened; then the incision in the uterus is made in the mid-line, beginning at the fundus; the placenta and membranes, as well as any clots of blood, are removed; the ligature is tightened then, and not until then, unless there have been severe hæmorrhage, as from the incision hitting the placental attachment; the ligature is tightened to facilitate the application of the sutures, of which two layers are applied; the deep are inserted by passing the needle from within outwards, the decidua only being left out; then intermediate sutures are applied to the peritoneum only, and Lembert's suture is usually adopted for these.

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— Dr. Fernel (*Gaz. des Hop.*) has studied at some length the effects of obesity upon pregnancy. In *résumé* we learn from his work that polysarcia causes: sterility, through the intermediary of languor of the ovarian functions; abortion, by asphyxia of the embryo, by provocation of contraction from carbonic acid in excess, and by utero-placental hæmorrhages as a consequent of a fatty heart; difficult accouchement, by opposing to a feeble impulsion an exaggerated resistance; dangerous accouchement, because death may result if the heart is fatty; and finally, polysarcosis is an obstacle to lactation.

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— Reiss (*Pharm. Journ. and Transact.* No. 2) claims to have used eserine sulphate with remarkable success in chorea. Subcutaneous injections of 0.001 gr. were given twice daily. From a contributor's experience with eserine in spasmodic affections of the ocular apparatus, twitchings of the eyelids and spasms of the ciliary muscle, we incline to the opinion that satisfactory results would be obtained in chorea, in hysteria, and in exaggerated reflex movements, if we had careful provings of the drug to guide to its selection in the troubles.

— In the treatment of women we meet with so many varieties of deception among hysterical patients that any study of differential diagnosis aids us to forearm ourselves. In making a study of pseudo-angina pectoris of hysterical nature the following tabulation will be found of great value :

## TRUE ANGINA.

More frequent at the age of arteriosclerosis, after forty or fifty years.

More frequent in men.

Provocation by any act requiring an effort. Spontaneous sometimes, relatively rare.

Rarely periodical and nocturnal.

Paroxysm isolated from other symptoms.

Vaso-motor form rare.

Pain, agonizing, with sensation of compression.

Pain of short duration (2 to 15 minutes).

Attitude of patient : Silence, absolute immobility, making the pain disappear in most cases.

Seat and anatomical cause of the disease : Arterial system, coronary sclerosis.

Grave affection, often causing death.

## HYSTERICAL PSEUDO-ANGINA.

At all ages, even from the age of six years.

More frequent in women.

Exceptionally produced by an effort. Most often spontaneous in origin.

Frequently periodical, coming on at fixed hours, and nocturnal.

Paroxysm associated with nervous symptoms.

Vaso-motor form frequent.

Pain, less agonizing, with sensation of distension of the heart.

Pain, often of long duration (1 to 2 hours.)

Attitude of patient : Incessant agitation, immobility not causing the pain to disappear.

Nervous system : neuralgia of the nerves and cardiac plexus.

Benign affection, never causing death.

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— Our Cuban *confrères* have not been fortunate lately in their operations. The last issue of *La Cronica Medico-Quirurgica* reports two cases of laparotomy, both fatal in result. In one case, reported by Dr. Santiago Veve, abdominal hysterotomy was performed for dystocia due to complete obliteration of the cervical canal ; death followed in thirty-six hours. In the other case,

reported by Dr. A. Barrena, laparotomy was performed for a vegetating cyst of the left ovary ; death resulted from acute septicæmia.

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— A writer calls attention to possibility in children of mistaking the symptoms produced by a foreign body in the larynx for those characteristic of other diseases. We think that this is especially the case in small children where the history is often unsatisfactory and a laryngoscopic examination impossible. Take the case of an infant, for example, where no history pointing to the lodgment of a foreign body in the larynx can be obtained. Here the symptoms may, according to the situation, size and character of the foreign body, simulate (*a*) spasmodic croup, (*b*) true or membranous croup, (*c*) laryngismus stridulus, (*d*) retro-pharyngeal, or deep-seated cervical abscess.

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—(*a*) *Spasmodic Croup*.—In spasmodic croup there is usually a history of coryza and slight laryngitis proceeding the onset of the attack. In spasmodic croup, although the dyspnœa may be urgent, the difficulty of inspiration is greater than that of expiration. In the case of foreign body impacted in the larynx, the expiratory effort is as great as the inspiratory effort. In case of spasmodic croup, the cough is loud, brassy, and sonorous. In impacted foreign body, the cough is smothered and suppressed. In case of a small, sharp object, the croup may be frequent and harassing, but not croupy. The voice and cry in spasmodic croup is more or less hoarse and husky. In case of a foreign body, closely impacted and nearly occluding the larynx, it is suppressed and smothered.

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—(*b*) *True or Membranous Croup*.—As in spasmodic croup, the history is all-important in the absence of laryngoscopic examination. In true croup we get the history of slow invasion and gradual development. From an insidious commencement the symptoms gradually and slowly increase. The voice, at first but slightly hoarse, gradually becomes more and more husky. The cough, at first hoarse, gradually becomes muffled until like the voice it becomes suppressed. The fever increases with the ad-



vancement of the disease. This is not the history of foreign body and clearly distinguishes true croup from impaction of a foreign substance in the larynx.

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—(c)—*Laryngismus Stridulus*.—In laryngismus stridulus there is spasm of the glottis, the patient becomes cyanosed and seems upon the verge of suffocation ; then the spasm relaxes, and there is a loud crowing inspiration, and the paroxysm is at an end. There is no cough, no fever, and the respiration is normal between the paroxysms. In case of foreign body, the dyspnœa becomes constant when it is of sufficient size, and when its location is such as to interfere with respiration ; otherwise, the symptoms are not at all analogous with those of laryngismus stridulus.

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—(d) *Retropharyngeal and Deep-seated Cervical Abscess*.—These two affections may produce dyspnœa and symptoms which may be mistaken for a foreign body in the larynx. In case of deep-seated cervical abscess, there is more or less external swelling. Examination with the finger will reveal the internal swelling, which causes the dyspnœa, and should make the diagnosis certain. In retro-pharyngeal abscess, a careful examination with a good light usually reveals more or less bulging of the lower posterior wall of the pharynx, which upon examination with the finger is found to be fluctuating. In either case there is a history of gradual development, which is quite the opposite from that of a foreign body.

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## ● GOLDEN GRAINS. ●

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—The use of lime-water is in part only an illusion, if given for the purpose of neutralizing an acid condition of the infantile digestive tract. It is a failure because it contains only a single grain to nearly two fluid ounces of liquid. But when added to cow's milk in sufficient quantities (1 : 3-6) it certainly makes it more digestible.

—There seems to be no limit to the wonderful therapeutical range of antipyrin (in the old-school mind). Several cases of inveterate incontinence of urine in children between four and eight years of age are reported to have been immediately relieved and ultimately cured by the administration of from ten to fifteen grains of the drug at six o'clock in the evening, the dose being repeated at eight or nine o'clock.

—The action of cold, received as a shock, so to speak, can give origin among young girls, to a rapid effusion of serum into the abdomen, that which Cruveilheir has called the *ascites of young girls*.

—Castoreum has cured watery or green mucous stools in delicate nervous children, who weaken under summer heat or during dentition, and who will not rally under the usual remedies. There is colic before the stool. The child seems to double up with the pain. There is also twitching of the muscles with great exhaustion. It may be found of especial use when the case has progressed well to a certain point, and there seems a lack of nervous reaction tending to unduly prolong the convalescence.

—The prognosis of infantile ascites, according to Leudet, is in general very favorable. Whether it is primary or secondary it yields more or less readily to repose, to regimen and to a treatment which will be varied accordingly as one decides upon visceral troubles or upon dyscratic troubles as the origin.

—The bromide of potassium has been advised as curative of ovarian acne. In the *Practitioner*, Dr. Jamison relates a case where the bromide of potassium, administered to relieve a too abundant menstruation, not only produced the desired effect, but caused a remarkable modification of the skin of the patient, which was the seat of a marked form of acne. We believe this to be a case where an old-school mind has unwillingly blundered upon a homœopathic application of potassium bromide.

—The theory and practice of insisting on giving puerperal women gruels, beef teas, toast-water, etc., from the first to the ninth day after confinement is not founded on a proper understanding of facts. Not only is it irrational, but it may be in some cases a positive detriment to the patient. A moment's con-

sideration will show that the organs connected with parturition will be more rapidly restored to the normal condition prior to conception, that the tissue changes, which we call involution, will be more quickly and perfectly accomplished, and that the new function of lactation will be more surely and plentifully established by a diet the opposite of the starvation advised.

—The pain under the left breast, so often met with in women, especially in such as are of a nervous temperament, whether it be a myalgia or a reflex symptom from ovarian irritation, is rapidly controlled by *Actea racemosa*.

—Acute coryza in infants always offers a grave prognosis. The accumulation of mucus in the nasal cavities causes great difficulty in breathing, insomnia, and also a certain amount of fever. The prognosis is still more unfavorable if the disease takes a chronic form. The affection may be very intense and be accompanied by fever and gastric troubles. Finally, it may also give rise to other serious troubles, and extend to the larynx and bronchi.

—In the gastralgia of women originating in spinal irritation or in ovarian disturbance, when the pain is acute, darting to the left and downward to the umbilicus, and is attended with the feeling of faintness in the stomach, or as is sometimes expressed, "gone-ness," *Actea racemosa* has been found very useful.

—Sänger (*Nouv. Arch. d'Obstet. et de Gyn.*) regards the theory of fatty degeneration as a factor in the involution of the puerperal uterus as false. He has examined the muscular fibers of seventeen uteri hardened in alcohol. A portion of these were from nongravid and a part from puerperal women confined at different periods of gestation. Microscopically it was found that the length and breadth of the bundles of muscular fibers were all different. During pregnancy they were very much lengthened and broadened. After confinement the lengthening and broadening disappear. But while diminution takes place, particularly in the third week after confinement, at the beginning during the first hours following birth the bundles broaden and shorten. These changes correspond to the contractions of the uterus after confinement. In the transformation fat may be produced outside

the muscular fiber, and the proof is the occurrence of fatty embolism. We find it only in the intervals between the muscular bundles. There is, then, during involution neither disappearance of muscular fibres nor new formation. The muscular fibers are transformed in a manner which may be termed paratrophic. Subinvolution of the uterus is, then, a fault of nutrition due sometimes to inflammation. The puerperal atrophy of the uterus is the result of an exaggerated regression of the muscular fibers and of the conjunctive tissues.

—During the climacteric several symptoms of *actea rac.* point to its being useful in some cases. Thus, when we find the usual "flushes of heat" associated with depression of spirits, restlessness, headache, the pain being at the vertex, a sense of sinking or faintness referred to the epigastrium, and more or less sleeplessness, it will be prescribed with advantage.

—Convulsions in neuropathic children are sometimes the prelude of genuine epilepsy. In the prognosis of eclampsia infantum this should be remembered, and the causes of a neuropathic diathesis looked for in a blood-relation of neuropathic parents, in procreation during a drunken spree, in the neuroses of pregnancy, or in nervous manifestations in the nurse during the nursing period.

—Phenacetin has been given with success in whooping-cough. Dr. Heimann, who has been investigating its properties in this direction, has given as much as 15 grains of it to children of four years without perceiving any ill effects.

—M. Lihobztky (*Gazette de Gyn.*, Oct., 1889) reports a case in which after having performed an operation for the removal of cancer of the rectum, after Kraske's method, the patient recovered good health. She afterward became pregnant and was delivered of a living child. It was interesting, in this case, to follow the mechanism of delivery. Labor was effected, in the absence of the sacrum, by the muscles and ligaments of the pelvic floor.

The delivery being normal proves that in multiparous women, or in women of large pelvis, the pressure of a resisting pelvic floor is not indispensable to the rotation of the occiput.

—*Lilium tigrinum* approaches somewhat to *sepia* in its effects upon the circulation, particularly the nervous, and still more especially does it stand near to *sepia* in those nervous affections that depend for their existence upon circulatory disturbances of the female genitalia. Both have nervous irritability, depression, and a feeling that she must be busy about something. But with all these symptoms common to these two drugs there are essential differences. The *lilium* patient finds relief in diverting her mind by busying herself ; while the *sepia* patient has relief from many of her nervous symptoms by violent exercise. It is, in the former case, a sexual erethism, produced by the pelvic venous stasis, that is relieved ; in the latter, relief is general by favoring the venous circulation of the pelvic organs, nervous erethism being but slight and associated with lessened venereal passion.

—Physicians who have infant food sent them for examination, should not rely wholly on the chemical analyses made by reputable chemists, and should not depend at all on the statements and analyses furnished by the manufacturers. The food should be subjected to microscopical examination by the physician *himself*. Place the food under the objective and study for gluten cells, starch granules, cellulose, and the connective tissue of the various cereals. Foods may be first class, chemically considered, and yet contain so much cellulose that they are unfit for the stomach.

—Twenty-five per cent. of all cases of *invagination* or intussusception of the bowels occur in the first year of life (two-thirds of them between the fourth or sixth month), and fifty-three before the end of the first year. Thus a knowledge both of the condition and of the means to remedy it are essential to every person who has many children intrusted to him. The only successful treatment consists, of course, in the reposition of the intestine. When this has been accomplished the relief of all the symptoms is immediate. The anxious expression, the pallor, and the collapse improve instantly. Besides the ordinary mechanical measures, such as inflating the intestine with air or gas, Dr. A. Jacobi (*Arch. of Pediatrics*, vol. vi. No. 70) advocates the following simple plan : The baby is turned on its belly, the hips are raised, the abdomen gently supported by a soft pillow. The mouth and nose,

being the lowest part of the body, must be protected. The baby is then anæsthetized with chloroform, and warm water is poured into the rectum with but little pressure. The injection is frequently intermitted, while the anus is closed by the finger. At the same time the abdomen, in the direction from below upward, is gently kneaded and its contents moved about.

—The well-known name of D. Berry Hart is appended to an article in the *Edinburgh Medical Journal* on the minute anatomy of the placenta in extra-uterine gestation. A study of the microscopical sections in connection with this work leads us to some conclusions with regard to the influence of the site of the placenta on the mode of termination of extra-uterine pregnancy. Taking the foetus and placenta together they may lie : (a) in the Fallopian tube ; (b) in the broad ligament ; and finally by growth come to occupy (c) either placenta extra-peritoneal, foetus intra-peritoneal ; or (d) both extra-peritoneal. Bearing in mind that the placental villi and intervillous sinous system are essential to foetal nutrition, it is found that in Fallopian tube gestation the villi are well formed and that sinuses occur in the muscular wall of the tube. As the gestation advances, and the displacement of the whole ovum occurs toward an abdominal gestation, the placental growth passes into the pelvic connective tissue and finally becomes extremely displaced, while corresponding changes in its structure take place. First, when in the pelvic connective tissue, there are fairly perfect villi, decidual cells, blood crystals with large areas of extravasated blood. But, in extreme displacement of the placenta toward an abdominal gestation, the placenta is converted into a mass of organizing blood clot. Broadly, therefore, the development of the placenta in the extra-peritoneal form of extra-uterine gestation is a destructive one, and from this there may be pointed out an important bearing on the life of the foetus and on the terminations of pregnancy. One of the most common terminations is to have foetal bones discharged per rectum, or in fact in pelvic abscess. Such are evidently extra-peritoneal developments, where the destructive placental processes have killed the foetus, and where proximity to the bowel unprotected by peritoneum has led to the endosmosis of intestinal gases or to the passage of micro-organisms.

## ● GYNECIC ETCHINGS. ●

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—Romeo (*Nouv. Arch. d'Obstet. et de Gyn.*, Mai, 1889), has made investigations on the rôle of the placenta in foetal pathogeny. He reaches the following conclusions :

1st. In the physiological condition the placenta constitutes an insurmountable barrier to the passage of foreign elements which circulate in the maternal blood. In other words, the placenta is a true filter.

2d. In case these elements gather in the placental lacunæ and provoke an inflammation or any other lesion capable of destroying the villousities, the barrier is then crossed by the pathogenic elements. Micro-organisms may thus pass from the maternal to the foetal circulation, carrying to the foetus the malady of the mother.

3d. If these pathogenic micro-organisms, for reasons which we do not know, are incapable of gathering in the placental lacunæ, or if accumulating there, they are incapable of causing in the tissues of the placenta any lesions, their passage from the maternal blood into that of the foetus does not take place, and the product of conception remains free from all diseases of the mother.

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—Valeriana has been so much used and so *abused* by the old-school that homœopathic physicians are too apt to neglect it. But it and its salts occupy a definite place in gynæcological practice, and especially in the treatment of hysteria. It is not so much adapted to hysterical spasms, with unconsciousness (as with musk and asafoetida), as it is to a general state of nervous and vascular excitement. Both mind and body are in a condition of irritation. The patient is lively, joyous, talking rapidly, with rapid chasing of thought after thought. Sometimes she imagines she is beset with dangers, or surrounding objects seem strange. She suffers from headache, giddiness and restlessness. Her muscular organism is so irritated that she cannot keep quiet, she must move about. The same state influences her pains.

The provings show twinging, drawing, cramp-like, stinging, or darting pains, all worse when she sits and better when she walks. The circulation, too, is excited; her head feels full to bursting; constant heat and uneasiness; dry heat in the evening while sitting, flushes of heat. She is wide awake and restless all night, falling into a dreamy sleep toward morning. Digestion also suffers in the general nervous disturbance. Before dinner she has a taste as of foetid tallow, while early in the morning, on awakening, the taste is flat and slimy. Nausea, as if a thread was hanging in the throat, arising from the region of the umbilicus, and gradually ascending to the fauces. Bloated abdomen.

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—M. Doleris (*Annales de Gyn. de Paris*) severely criticises the present tendency of abdominal surgery, and charges many prominent operators with too great precipitation in deciding on extirpation of both ovaries and tubes. He thinks that in too many cases we lay women liable to great dangers by castration when it is a question whether the case can be best treated medically or surgically. He has even known organs to be extirpated that on examination revealed no important alterations. The second part of his article treats of artificial evacuation of the encysted contents of a tube, after salpingitis, by dilatation and drainage of the uterus. In this, the treatment is given in the following details:

1. Dilatation of the uterus by laminaria tents and sponges, antiseptically prepared. It is necessary to dilate the uterus uniformly, and maintain this dilatation during several days.
2. Cleaning minutely the cavity of the uterus, especially in the region of the os uteri; clear the orifice of discharge of liquid from the tubes, of fungosities of the nature of obstruction to the flow of liquids.
3. Drainage made with iodoform gauze, which is packed carefully into the cavity of the uterus. This method of treatment has given excellent results to the author.

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—The salt of valeric acid following next after valeriana, as a remedy for hysteria and internal trouble, is the Valerianate of



zinc. Farrington says of this drug that he does not remember to have failed to cure in a single instance what has been generally termed the fidgets in hysterical and nervous persons. They cannot sit still, or they must keep the legs in constant motion. Corresta T. Canfield, of Chicago, claims that this preparation of Valeric acid has proven curative in neuralgic dysmenorrhœa. There is pain in *either ovary, accompanied with nausea* and neuralgic headache. Neuralgia of the ovary, *worse during the menses*; differing from Zincum met., in that in the latter the pain is *relieved during the menstrual flow*. In one case, a lady, æt. 34, no children, suffered at her menstrual periods with an excruciating, *drawing pain* in the left ovary. Pain usually accompanied with *nausea, vomiting, and headache*. Cured by Zinc. val. 2x. In another case, a woman, who had syphilis in her younger years, was nearing the climacteric. During her menses she experienced a *gnawing, drawing pain* in the right ovary. Pain extended through to back, to right of spinal column, just above the sacro-iliac symphysis. Zinc. val. 2x always relieved these symptoms.

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— Apropos of *Valeriana* and its congeners, Dr. Farrington wrote a valuable summary of the comparative indications of this remedy and those which approach it closely in their relationships to hysteria.

*Moschus*—Excited, scolding, fainting; coldness; spasm of glottis and lungs.

*Castoreum*—Exhausted, pains better from pressure; menstrual colic with pallor and cold sweat.

*Nux Moschata*—Errors of perception, drowsy; faints; enormous tympany; oppression of heart to throat; skin cool.

*Valeriana*—Nerves irritated, cannot keep still; tearings, cramps, better when moving; taste of tallow or slimy.

*Asafetida*—Reverse peristalsis, rancid eructations, offensive flatus; tightness of the chest; checked discharge.

*Magnesia Muriatica*—Faints at dinner, relief from eructations; head better from pressure and wrapping up; palpitation better on moving about; stools crumble.

— Dr. Pierre Delbet (*Annales de Gynécologie* for September, 1889) has been conducting a series of interesting researches, on the dead subjects and on dogs, intended to settle some vexatious question concerning the various methods of flushing the peritoneum during abdominal operations. He reaches several conclusions. The liquid employed for flushing is diffused over the whole of the peritoneal cavity. Foreign bodies cannot be entirely displaced by flushing; hence, although septic material may be dislodged till but little remains, that little may do harm; on that account it is, in Dr. Delbet's opinion, best to flush with an antiseptic solution after plain water has been employed. After flushing, a considerable amount of liquid remains behind, occupying the pelvis, iliac fossæ, and flanks. Dr. Delbet comes to a remarkable conclusion respecting the temperature of the water. The temperature, within the limits of  $64^{\circ}$  to  $122^{\circ}$  F., has no appreciable effect on the respiration or circulation, therefore there is no danger that flushing can arrest the heart's action. It is admitted, however, that flushing with water of low temperature chills the intestines and increases shock. The water should be heated to  $100^{\circ}$  to  $102^{\circ}$  F. The alleged hæmostatic action of flushing with very hot water appears doubtful to Dr. Delbet. During the first minutes of the flushing process a great quantity of the water is absorbed. When the salt in the proportion of seven parts to one thousand of water is employed, the process becomes "a true indirect transfusion." There is an interesting conclusion on the absorption of the poisonous antiseptics (corrosive sublimate, carbolic acid, etc.) that is of great value to those who use these preparations. After flushing the peritoneum for ten minutes with a saline solution, a fluid containing a poisonous element may be diffused over the peritoneum with impunity, provided that it be followed by another flushing with the saline water. These experiments indicate that flushings with relatively strong solutions of sublimate and of carbolic acid may be advantageously used, provided that the proper precautions are taken, and that those operators who neglect these precautions in the use of the poisonous antiseptics do so at the peril of the patient's life.

## ORIGINAL TRANSLATIONS.

The Editor is assisted in this department by Dr. S. Lilienthal, San Francisco, Dr. H. H. Crippen, San Diego, Cal., and Drs. Pick and Pritchard, Boston.

ON HABITUAL INVERSION OF THE UTERUS, DURING DELIVERY OF THE PLACENTA.—Prof. G. Braun wants to have habitual inversion of the uterus to be taken in the same sense, as one speaks of habitual abortus. (1) A multipara, felt suddenly, after some severe paroxysms of cough, before the placenta could be delivered, a large tumor between her thighs, though no traction took place on the cord. Moderate hæmorrhage, reinversion by pressing it up with both fists, whereby the placenta became partially loosened, and, after the uterus was in place again, the placenta was extracted. Puerperium normal. (2) A woman was unexpectedly delivered while standing and the fundus uteri followed the traction of the cord. Reinversion in less than two minutes by the usual method. (3) A IV-para elevated the pelvis for cleansing purposes; when suddenly the inverted uterus with placenta attached fell out of the vulva under copious hæmorrhage. The midwife was not to blame. Reinversion only succeeded after detaching the placenta. Death from high-graded anæmia. (4) Multipara, inversion by raising the pelvis. (5) Multipara, had an inversion of the uterus with prolapsus already during her first labor. Labor this time had been natural, whereas the third stage was protracted notwithstanding massage. The hand was then introduced to extract the placenta. Inversion followed during the extraction, probably in consequence of the extraordinary relaxation of the uterus, as during the removal of the hand a space with negative pressure must have formed, performing some sort of suction. Reduction, massage, ergotin injection, and especially intra-uterine irrigation, with cold four per cent carbolic solution, produced sufficient contraction of the uterus. Traction on the cord is not so much to be blamed as abdominal pressure in the horizontal position, where great atony of the uterus prevails, and in all such cases it ought to be forbidden. *Wien. clin. Wochenschr.*, 22, 1889.

ARTIFICIAL EMPTYING OF SALPINGITIS EXUDATIONS BY SLOW DILATATION WITH LAMINARIA AND CONSECUTIVE UTERINE

**DRAINAGE.**—By DR. DOLERIS.—Instead of the usual surgical method, Doleris recommends a conservative treatment on total affections, because—(1) Salpingitis may get well with simple rest and good nursing; (2) It is a well-known fact that an encysted relapsing exudation loses its septicity, the longer it exists; (3) Certain kinds of hydro- and pyosalpinx are sequelæ of simple congestion or of a mechanical character (spasm and atresia of the canal at one point, and a pyo-salpinx may follow an aseptic hydro- or hemato-salpinx; (4) the spontaneous discharge of intra-tubal pus in the peritonæum, into the uterus, or the artificial emptying of septic tubal cysts without extirpation of the organ by laparotomy or per vaginam, is nearly always followed by a cure; (5) Extirpation of the tubes and ovaries is followed by mortal and material consequences, while a woman with diseased tubes need not necessarily become sterile, though it is usually the case. He introduced into the cavum uteri a laminarium and leaves it there. The dilatation of the walls of the uterus causes also a dilatation of the lumen of the tube, shortens at the same time the length of the organ, increases the intra-tubal tension and facilitates the evacuation in the cavum uteri, where the pus is absorbed by the laminarium. A few days afterwards the uterus is well curetted, and especially at the points where the tubes enter the uterus. Where fungosities are present, this must be followed by a drainage of the uterus with iodoform glycerine gauze. The tumors nearly always disappear after such treatment. Some relapses may happen during the next menstruation, and it is advisable to look well after the patient.—*Allg. Med. Centr. Zeit.*

**ON THE PATHOLOGY AND THERAPY OF PYOSALPINGITIS.**—By DR. QUINN.—Different views are held about the mechanism of the origin of pyosalpingitis. Lucas, Championnier and others consider it only a direct, immediate continuation of the inflammation, which primarily was seated in the parenchyma of the uterus and through the regionary lymph courses progressed to the tubes. Quinn considers it rather a progress of the inflammation *per saltum*, analogous to the fact that an urethritis may be followed by an epididymitis, or a cystitis by a nephritis, though the tissues connecting these organs are not attacked by the same affection.

In fact, the conditions for analogous inflammations are in so far very favorable between the uterus and the tubes, as the structure of the mucous membrane in both organs shows many analogies. The fact that the pus found in pyosalpinx contains gonococci, which are never detected in the lymphatics of that region, shows precisely the pathogenesis of this affection. Per contra the abscess forming ovaritis is nearly always the result of a lymphangitis of the vessels coursing between ovarium and tubes. Quinn cannot agree with Noatier, who considers laparotomy the sole indication, for of eleven cases of pyosalpinx, treated during the last two years, five were cured by simple rest and antiseptic-absorbing vaginal treatment, especially where only a short time passed since infection. All internal modes of treatment must be exhausted, before the radical operation is recommended. In four cases he removed also all the adnexa; in one case the adhesions were so strong, that he was satisfied with opening of a retro-uterine abscess. Unforeseen rupture of pus sacs with consecutive discharge into the peritoneum may be prevented by surrounding the abscess with antiseptic sponges, and where it fails, outward drainage suffices to prevent septic manifestations.—*Allg. Med. Centr. Zeit.*, 29, 1889.

**AINHUM AND CONGENITAL AMPUTATIONS.**—Silva Lima and Pereira Guimaraes, of Rio Janeiro, have shown that ainhum consists in a spontaneous and gradual section of the fifth toe, facilitated by the absorption of the bone and fatty transformation of the tissues. It always occupies the fifth, sometimes also the fourth toe. Numerous facts prove it a hereditary affection, appearing in the adult after puberty, usually without any pain. It attacks the negroes, but other physicians observed it also among the Hindoos: accoucheurs observed often enough congenital or spontaneous amputations, not only of the toes, but also more or less of the extremities, but many differences can be pointed out. Anatomically one finds in ainhum a fatty transformation of the tissues preceding the spontaneous section, causing degeneration of all the tissues of the toe. Suihard has shown that in congenital amputations we find enormous hypertrophy of the skin, which lost its glands, and one meets only a fibrous transverse constrictor furrow totally different from ainhum. In relation to ainhum the

U. S. N.

cause is not known. Writers speak of partial lepra, of vascular spasm, of trophic troubles, while in congenital amputations, mechanical foetal disturbances are mostly blamed. Ainhum is hardly ever observed before the twelfth year, while congenital amputations are observed at birth and in the white race.—*Semaire Méd.*, 22, 1889.

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### RESOLUTIONS ON THE DEATH OF DR. H. K. BENNETT.

ADOPTED BY THE BOSTON GYNÆCOLOGICAL CLUB.

WHEREAS, Our beloved friend and professional brother, H. K. Bennett, has completed his life-work here on earth, and passed on to that which lies beyond—we would give expression to our sorrow at his loss, and to our sympathy for those to whom he was so much nearer and dearer than to us :

Therefore—Be it *Resolved*, That in the death of Dr. Bennett our Club loses one of its most earnest, active and devoted members ; one to whom more than to any other it owes its birth—and one who has sacrificed much and labored hard to promote its interests and secure its success.

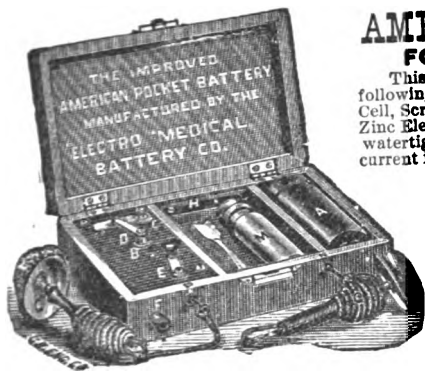
*Resolved*, That in our personal relations we each and all of us lose a warm-hearted, genial, unselfish friend—one ever ready to lend a helping hand, or give counsel in time of need.

*Resolved*, That we extend to his family, who are bereaved of a fond and loving husband and father, our heartfelt sympathy in their affliction.

*Resolved*, That these resolutions be incorporated in the records of the Club, and a copy of them be sent to Mrs. Bennett in token of our recognition of her greater bereavement and our remembrance of our departed friend.

L. A. PHILLIPS,  
W. H. LOUGEE,  
*Committee.*

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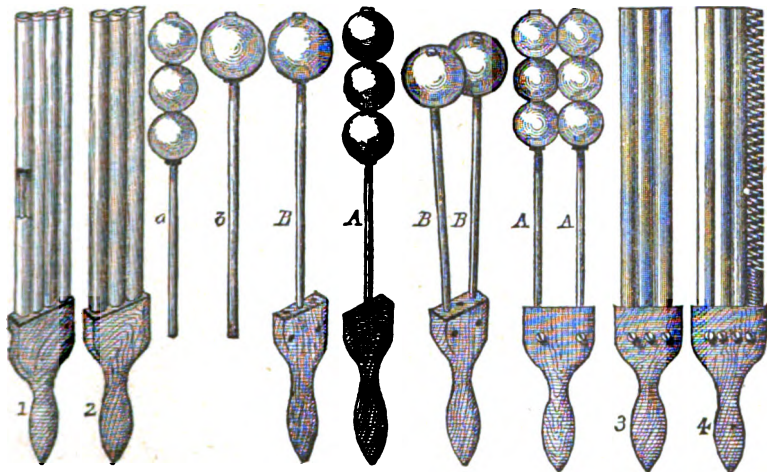
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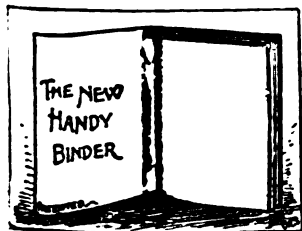
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VOL. XII.

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## REMARKS CONCERNING THE THIRD STAGE OF LABOR.\*

BY

G. MAXWELL CHRISTINE, A.M., M.D.,  
PHILADELPHIA, PA.

The question as to what is the best method of treating the third stage of labor is constantly recurring. The answers from time to time given show a varied custom. Some practitioners prefer to leave the expulsion of the placenta to nature or at most to the supposed or real dynamic power of medicine; some resort to immediate efforts at removal; others still occupy a medium ground and permit a reasonable length of time to elapse after the birth of the child before attempt is made at interference, the length of time and the character of interference depending on the indications.

Occasionally, the expulsion of the placenta from both uterus and vagina will immediately or very quickly follow

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\* Read before the Homœopathic Medical Society of the County of Philadelphia, Nov. 14, 1889.

the birth of the child. It may, however, be so bound to the uterine walls, by adhesions, or so held in bondage by abnormal and irregular contractions of the uterus, as to successfully resist the application of any ordinary method for its delivery, and to so be and remain for hours and days, in the mean while subjecting the woman to the horror of infection and hæmorrhage.

These two facts, the occasional speedy and occasional long-retarded delivery of the placenta, together with those which have their happening between these as extremes, furnish perhaps the reason for the variance of views held by accoucheurs as to *the* treatment of this stage of labor, for the difficulties attending the delivery of the placenta are not uniform with practitioners. Men of large and long obstetrical experience have been known never to have had any marked difficulty attend the delivery of the after-birth. With them, it has always been sufficient to resort to slight abdominal pressure, and moderate traction on the cord, and the placenta is born. Other men are not so fortunate, complications of various kinds frequently demanding a far different mode of procedure than this. The former mentioned practitioners have sometimes advanced their methods as all sufficient and never-failing. The latter may recognize certain principles as ever underlying the basis of operation, but each case is really to be treated on its individual indication.

The separation of the placenta from the uterine wall is ideally simultaneous, or very nearly so, with the first respiratory act of the child. As to how this separation is effected the theories are many. Contraction of the uterus at the points of union with the placenta is a theory strongly urged, and one which is plausible. The contracting uterus compresses the placenta and may thus loosen it. It is possible that each of these theories has a measure of truth in it, either one acting separately or both together. Whatever is the immediate cause, it is anticipated by a degenera-

tion taking place, toward the close of the pregnancy, in the villi and in the incidental layer between the placenta and the uterus, and by a deposit of calcareous patches on the placenta's uterine surface—(Playfair). If this process has preceded normally, the separation is readily effected by the acting forces; but if it has been imperfect, or adhesions have taken place by reason of inflammatory causes, the separation is only partial.

The attendant conditions of the third stage of labor are, therefore, not a fixed quantity. Hence, no inflexible rule can be laid down for the guidance of the practitioner. To-day, he will have a case in which the detrusion of the placenta follows quickly and unaided except by maternal forces, upon the birth of the fœtus. To-morrow, he may be so unfortunate as to have a case requiring for their treatment all the artificial aids now employed for the separation of an adherent placenta, the life of the woman being, in the mean while, greatly in danger from post-partum hæmorrhage. Indeed, but few cases correspond in the requirements they present for treatment. General principles and methods of procedure may, however, be recognized, and on these as a basis of operation is constructed the treatment of individual cases.

Unless hæmorrhage ensues, or threatens, after the birth of the child, in which event a special plan of action is indicated, it is well to wait a few moments or minutes until pulsations in the cord have ceased, before it is ligated. This gives time for the uterus to regain its contractility and for the processes of separation of the placenta from the uterus to be perfected. Whether ligation should be single or double, is still mooted. I prefer the double ligation for two reasons: 1, it makes the operation of cutting less bloody, and, 2, it keeps blood in the placenta, and thus preserving its size facilitates its removal through uterine contraction. After disposal of the child, place one hand over the fundus and follow with a finger of the other the cord up

to within the uterus. The first hand will give us information as to the condition of the uterus; and the second, information as to the position of the placenta, the existence of hæmorrhage, etc. This ascertained, the finger within the vagina can be withdrawn, but the hand on the fundus should remain there and not be removed, or if so for only a short time. If the uterus has showed no signs of contracting, that is to say, if it does not present a hard "feel" to the pressure of the hand, it can with good result be *gently* (!) rubbed and *slightly* (!) compressed until we conclude contractility has been established. This can generally be secured in a minute or so. Rubbing and compression of the fundus should now be desisted in, and the hand simply made to press against the firm ball-like uterus. We must not forget the ordeal through which the patient has passed, and must bear in mind the need of at least the average woman for a period of rest between the consummation of the second and the consummation of the third stage of her labor. In my own practice I regard this period to be about twenty minutes. The uterus is given time to recover its contractile powers, and the woman herself will then be better able to lend her own voluntary efforts to the accomplishment of the delivery of the placenta. During this interval, it is unwise to make any traction on the cord, unless the placenta is in the vagina and needs simply to be lifted out.

At the close of the twenty minutes the separation of the placenta has probably been perfected, the uterus has recovered its tone, the mother has in a measure regained her strength, and we can now safely proceed to the completion of the stage. The hand over the fundus gently rubs it, the woman is urged to bear down at intervals of about a minute, or at the times of the "pains," and the cord is sufficiently drawn upon to bring the placenta down into the vagina, if it is not already there, and if it has been loosened and extrusion is taking place from the uterus. The important point

is not to press too hard upon the uterus, nor to pull too forcibly upon the cord. Consequences very serious in their character have taken place owing to a disregard of this caution. As the uterus contracts and forces the placenta out, the hand on the abdomen follows the fundus until the act is completed. If Credé's method is to grasp the uterus within the hand and to fairly squeeze out its contents, nothing more harmful could be suggested. Charpentier condemns it most forcibly, but his direction as to traction on the cord itself is to be condemned as pointed out by Dr. Grandin, who gives as a reason for his condemnation that it is apt to produce uterine inversion, and to cause to be left behind placental or membranous shreds. Traction on the cord is also condemned by Dr. Grandin because it does not imitate nature's method, which is one of *vis a tergo*, not of *vis a fronte*. These objections are valid if they are urged against very forcible tension of the cord. Charpentier instructs the accoucheur to seize the cord with the hand, a towel intervening, while the other hand follows the retreat of the fundus. This direction is open to criticism, for it implies delivery by a decided *vis a fronte*, to which Grandin makes proper objection. There is still a *vis a tergo*, and it should be utilized, the *vis a fronte* serving simply as an aid. Traction on the cord, carefully and judiciously applied, the accoucheur bearing in mind the purpose of putting the *vis a fronte* under contribution, is simply to draw down the yielding placenta, and not to exercise a force on the uterus. Similarly, the added *vis a tergo* of the hand over the fundus must not, as Credé seems to suggest and is often the case, be so great as to push the uterus down into the pelvis. Charpentier says truly of this practice that it cannot be that massage of the uterus, exercised at a time when this organ, worn out by the efforts which it has made to give birth to the foetus, needs gentle management, is inoffensive to the woman.

If it were rightly known, uterine displacements may many

of them] be due to the application of Credé's method. Frequently, uterine disease follows child-birth as a sequel, and I believe that in many cases arises from the indiscreet employment of compressive force from behind the uterus. I admit that Credé's method of compressing the uterus facilitates the birth of the placenta, and thus saves time, but often "time saved is labor lost," and it is nowhere so true as in the third stage of labor. Very gentle but steady pressure (not compression, not squeezing, not pushing) on the fundus, with just a proper amount of traction on the cord, aided by the contraction of the uterus and the expulsive efforts of the mother, seem to me to be all that is necessary in the average case. It may take minutes or even half an hour or more, but we have undertaken to conduct our patient *safely* through the labor, and we have no right to sacrifice her future health and comfort to the saving of time.

If, after the lapse of a half-hour, the placenta does not readily yield to the method suggested, the aseptic hand can be slipped up the vagina and the finger hooked into the placenta, and slight traction exerted on the mass during maternal expulsive efforts. If this does not suffice, rather than squeeze the uterus, as Charpentier puts it, like squeezing a stone out of a cherry, it is much preferable to put the whole hand into the uterus and grasp the placenta, in which case uterine contractions are generally excited and the mass becomes easy of withdrawal. Adherent placenta, hour-glass or other irregular contractions, and hæmorrhage, are to be treated in special manner, and promptly.

I have now endeavored to give the method which ordinarily I find efficacious, and which, above all, I am positive effects no harm to the uterus. It is conservative, and stands midway between the extremes of current practice. A certain practitioner of this city, after ligating the cord, immediately thrusts his hand into the vagina and uterus, and pulls forth the placenta without regard to condition.



He contends that he has no bad result to follow, but in this I believe him to be greatly mistaken. As Ramsbotham points out, this was almost the method resorted to by Paré, who advised it if pulling upon the funis did not suffice. But Paré's followers "so rudely thrust their hands into the uterus on all occasions, tearing the placenta so rudely away," that "the most disastrous results followed." This was superseded by the opposite method—that practiced by Hunter and Ruysch, who each left the expulsion of the placenta to nature. Ramsbotham remarks that in the obstetric department of the Middlesex Hospital, "the occurrence of some fatal cases induced Mr. Hunter to modify his treatment." Before his death, Hunter recommended the withdrawal of the placenta at the expiration of four hours. This was evidently an effort at compromise between Paré's and his own earlier custom. If the practitioner could remain at the bedside of the patient four hours after the birth of the foetus, I can conceive of no very *very* great harm that would *generally* result from this later method of Hunter; but to do so is at this day impracticable. And to leave the patient alone, even with a nurse, for the space of four hours with an unborn placenta, is a dangerous practice, and though there are those who think it no harm so to do, there is too much danger from hæmorrhage to justify it. We should never leave the parturient woman with our duty only partially performed. When the uterus is thoroughly cleared out, contractions have been secured, the pulse indicates normal blood tension, and the woman is washed, bandaged and comfortably fixed,—fully an hour (preferably more than an hour) after the birth of the child, then and then only can we bid our patient good-by, and go to our home satisfied that we have done the full measure of our duty to the patient.

And now that I am on the subject of placentas, a reference to a new form of placental forcep is *à propos*. There

are numerous instances in which, after abortion in the early months, there is an escape of the fœtus with a subsequent contraction of the os which prevents the easy removal of the decidual or placental mass. The forcep most in use for the delivery of placentas in those early abortions is the Bond forcep. This forcep acts admirably in most instances, but when the os is small great difficulty is experienced in opening the blades of this and every other former pattern of forcep after it has been entered into the uterus. To obviate this difficulty I modified the Bond forcep, as set forth in the *Hahnemannian* of 1889. As there described it consists of the old Bond forcep lengthened and more curved in the legs, enlarged in the fenestra, and the fixed lock replaced by one of male and female pattern, somewhat after the plan of forceps for delivery at full term. The blades are therefore detachable. Since its make I have used it



several times with gratifying results. Several of my brethren have used it and testify to its meeting the indication suggesting its device. To use the forcep introduce the male blade first well up between the placenta and the (woman's) left uterine wall. Then introduce the other blade on the opposite side. Lock the blades and use traction or torsion as may be required,—of course with the necessary care.

Mr. Yarnall, the instrument maker of this city, has still further improved the instrument by adding a lock which enables the forcep to be used at will as an ordinary forcep or as a detachable-bladed forcep. As thus made the forcep has decided advantages over the former.

The above cut well pictures the forcep.

The blades are made firm and long to meet those cases in which a good grip is essential on the membranous mass, and in which the uterus may be high up and the placenta

difficult to reach. The fenestra are made large in order that portions of the contained mass may protrude through, thus aiding in the grip. It is well to have two pair of the forceps,—one light and delicate, and the other heavier and stronger,—though ordinarily a light pair answers the purpose.

The use of this forcep will almost, if not fully, obviate the necessity for forcible dilatation of the os in these cases of retained placenta in early abortions, and for the use of the curette, which frequently does great harm and is often unsatisfactory. With a firm grip on the placental mass, which with this forcep can quickly and readily be secured, the uterus can be stimulated into contraction, and by gentle maneuvers the mass can be withdrawn.

#### DISCUSSION.

Dr. T. S. Dunning said he had not heard all of Dr. Christine's paper, and did not know under what conditions he had recommended waiting a half-hour for the expulsion of the placenta. After citing a case of hæmorrhage in which the plan of waiting was pursued, he urged the necessity of the immediate removal of the placenta in all cases of severe hæmorrhage, without waiting for other means to be used first. Then, compression of the fundus and other means could be used to advantage.

Dr. M. M. Walker said that he had used the Credé method of delivering the placenta in several hundred cases, with the most satisfactory results, the following cases being exceptional:

Fourteen years ago he delivered a primipara aided by ether and Prof. Braun's Vienna forceps. He then delivered the placenta according to the above method without much force. The next morning he found an inverted uterus, which he quickly restored. Fortunately there had been no great hæmorrhage, and the woman was not retarded in her recovery by the accident.

On October 16, 1869, Dr. Walker delivered a primipara and thought he had an adherent placenta. He had been taught to pull gently on the cord, but in this case he was too gentle. After sitting up all night and giving the patient Puls. 200 in water every half-hour, he found the placenta was quite firmly held in the vagina and probably had been there most of the time.

June 29, 1884, he attended a woman with her second child. Fourteen months before he had been called in consultation when her first child was born. Then there was a firmly adherent placenta throughout most of its extent, which was forcibly torn away.

The labor of the second child was of nineteen hours' duration. Ether and Hale's forceps were used. After delivery, Dr. Walker waited ten to fifteen minutes, as he generally does, for a pain to come on, and then made effort to aid the expulsion of the after-birth, but it did not move. He introduced his hand into the cavity of the uterus and found the placenta very firmly adherent. It was necessary to tear the placenta from its attachments. The woman made a good recovery without further trouble. The doctor thought the Credé method the best, if not too forcibly indulged in.

In regard to forceps for removing the placenta after accidental abortions and miscarriages, Dr. Walker said he had frequently used the ordinary forceps with good results, but he thought that Dr. Christine's improvement of unlocking them a very good one.

In detaching the adherent placenta in these premature cases, he had used his fingers more frequently than instruments of any kind. By bending the forefinger backward and placing the tip of the long finger over it, great force can thus be exerted, in grasping pieces of the placenta; then by the usual scraping and scooping methods, aided by the contractions we induce while manipulating with the other hand externally, other pieces can be detached.

We do not always have instruments with us, but in our

fingers we have a good mechanical means always at hand. In detaching adherent placentas we must not be afraid to use considerable force judiciously applied. In many cases in which it was not possible to extract all the placenta, Dr. Walker has given Sabina 200, or lower, in water every half-hour, thereby reducing the hæmorrhage, and has often found the remnants of the placenta, at the next visit, to either be in the vagina or to have escaped.

In using the rolled and pared lemon for post-partum hæmorrhage, the doctor knew of a case where a physician introduced a lemon into the uterus for the above purpose. On the next morning, he attempted to take it away, but succeeded in getting only a small portion of it. Three weeks afterward the nurse found a large clot in the chamber, which she washed and there found three-fourths of the lemon. The patient had a double milk leg from which she was three months recovering.

Why not squeeze and strain the lemon juice and inject through a syringe?

Dr. B. F. Betts said that there were two indications for manual interference in the treatment of the third stage of labor. The first was the occurrence of post-partum hæmorrhage without uterine contractions: the other was the presence of uterine contractions without spontaneous dislodgment of the placenta from the uterine cavity. In the absence of the first indication (uterine hæmorrhage) Dr. Betts always waited for some evidence of the second indication before doing anything in the way of traction upon the cord or compression upon the fundus in the grip of the hand placed around it through the abdominal walls. To use manual means before there was some pain or evidence of contraction as felt by keeping the hand in contact with the fundus, will often do harm. Whilst the uterus is in an atonic condition after the violent contractions necessary to expel the child, we may goad it to renewed efforts, but they are often ineffectual, and even if the placenta does come

away, a clot will form, or a severe hæmorrhage ensue that may afterward interfere with recovery. Dr. Betts prefers to wait for the organ to regain its tone, before removing the placenta from the uterus by manual means, even if it takes twenty, thirty, or forty minutes for it to be accomplished.

Dr. E. M. Howard, of Camden, New Jersey, said that books and teachers of obstetrics fail to carefully differentiate the possible positions of the placenta, when speaking of traction on the cord. Young practitioners are particularly prone to fall into error in this respect. He had many times found the placenta wholly or partly within the vagina, immediately after the birth of the child, and had found it so tightly held by the contractions of the vagina, or by its shape, as to require *very strong* pulling to dislodge. Though agreeing with the paper regarding the dangers of anything but gentle traction while the placenta is retained within the uterus, Dr. Howard said he would advise the young practitioner to carefully locate it, and act accordingly. The doctor added that he had long since given up the practice of ligating the placenta end of the cord, and believed that the delivery of the after-birth is thereby greatly facilitated. He never could see any good reason for the second tying.

Dr. Charles Mohr said his first case was one of retained placenta, and like Dr. Howard he did not use force enough to remove it, and was compelled to call in assistance. The next case was one of adherent placenta, and having determined to get through with this case without calling in aid, he succeeded in breaking up the adhesions after having made other efforts, covering a period of twelve hours, to bring about its expulsion. Other experiences followed, and he concluded that every case of retained or adherent placenta must be treated according to the indications. Sometimes one method succeeded, sometimes another. He had found a simple change of position of the patient often of great use in making easy the delivery of the after-birth. In

some cases Credé's method was employed more successfully than other methods to effect delivery. In respect to Dr. Christine's modification of placental forceps, he thought a valuable suggestion had been made. When he began to practice medicine, it was with an idea that he who practiced homœopathy might get along with few instruments. So he was without placental forceps, but felt the need of a pair, when called to a case of retention of the placenta after an abortion at the third month. He therefore hurried to the nearest instrument maker, purchased a pair, and on his way back to the patient met the late Dr. Henry N. Guernsey, to whom he related the case, and what he intended to do instrumentally. "Placental forceps," Dr. Guernsey said, "are no good. Give the woman *aconite*." He followed Dr. Guernsey's advice, and after a few doses the bleeding stopped, and the placenta and membranes were readily expelled, and removed from the vagina by the fingers. Dr. Mohr had not been so successful always with the indicated medicine, and had been compelled to resort to mechanical means to remove placenta or portions thereof, but he had never attempted to use the ordinary forceps without feeling that they were entirely inadequate, and had in every case been driven to use his fingers. Perhaps Dr. Christine's modified placental forceps will fill the bill. He asked whether others had been as unsuccessful as he in the use of the ordinary instrument, and what hope Dr. Christine's forceps hold out that they will prove more effectual.

Dr. J. Nicholas Mitchell said that he arose to speak more particularly of one point referred to by Dr. Christine. He had noticed the liability of displacements of the uterus, from a too energetic pressure upon the uterus to expel the placenta. He had under his care three ladies who all suffered from a retroflexion of the uterus, and who were all attended by the same obstetrician. It interested him, in looking for a cause, to inquire into his method of treating his patients, and it was found that he was an extreme

advocate of Credé's method. Dr. Mitchell, however, wished to enter his protest against pulling upon the cord, so long as the placenta is in the uterus, and against putting the hand into the uterus to remove either placenta or clots except in some emergency, for expression of both placenta and clots can be safely brought about by pressure made over the fundus of the uterus, and no bad results need follow, if the pressure be made during a pain and without violence. With regard to the forceps Dr. Christine has shown us for the removal of the placenta after abortions, Dr. Mitchell indorsed what he and others have said about the difficulty of grasping anything within the uterus with the ordinary kind. He had therefore for some time used a pair one handle of which rotates in the other, so that while both can be placed thoroughly and high up in the uterus, this end can then be rotated around on to the other side and so grasp the placenta high up. Owing to the liability of tearing away only parts, however, he is in the habit of separating the placenta first with his hand or with Mundé's curette. This pattern that Dr. Christine shows, Dr. Mitchell thought would, however, be more satisfactory, though he would suggest to him that it were better if the blades were somewhat larger, with larger fenestra, and not serrated, somewhat like some of the forceps used to grasp the ovarian cyst after tapping in ovariectomy. It would be well also to have different sizes in one's case, and he would prefer that the blades fit into one another, rather than be locked by a screw, which might be in the way in some cases.

Dr. Williamson, president of the society, said an accurate knowledge of the condition of the parts was necessary, before deciding how to act; this was shown in a case of complete inversion of the uterus. Some years ago, while visiting Dr. Harlan in Wilmington, the doctor was called out in the night to a woman who had engaged a neighbor to take care of her at the birth of her second child. Her friend by pulling on the cord turned the uterus inside out.



When the doctor arrived he found the woman dead, the bed covered with blood, and a large quantity of blood on the carpet.

Dr. Christine, in closing the discussion, said that his paper by no means covered the subject,—it would require a long paper to do that, and the books on obstetrics so fully treated the subject, he would not presume to burden the society with a long dissertation. His purpose was more to elicit the opinion of individuals of the society, than to instruct the society. At the same time there were certain facts relative to the treatment of the placenta he desired to emphasize, and he was pleased to know that generally the members of the society agreed with him. In the treatment of the third stage of labor, we should first of all remember that nature itself will do much toward the expulsion of the placenta. The aid we render nature should be measured by the exact quantity of her inefficiency when such exists. If we do more than this it is interference; and nature abhors interference. The placental forcep presented was intended only for those retained placentas which occur in early abortions, and when it happens that the os has so contracted as to make it impossible to introduce the fingers or ordinary forceps for effectual work. The value of the lemon in post-partum hæmorrhages was urged. It is well to order that a lemon be handy in all lying-in rooms. During the labor, it should be rolled and placed with a knife in a convenient place. In case of post-partum hæmorrhage prior to the delivery of the after-birth, clear the uterus of all placenta and membrane in the speediest possible time. In the mean time the lemon has been cut and freed of seeds. Take one-half and pass up into the uterus and squeeze out the juice. The stoppage of the hæmorrhage is nearly always instantaneous. Of course, the lemon should then be withdrawn.

## SUB-INVOLUTION OF THE UTERU AND ITS TREATMENT WITH ELATERIUM.

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BY

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"Areolar hyperplasia," "chronic metritis," "parenchymatous metritis," "uterine hypertrophy," "enlargement of the uterus," and "sub-involution of the uterus," are terms which have been used by authors and writers during the past twenty years to denote a condition of the uterus produced by engorgement. I prefer to use the term "sub-involution," used first by Simpson.

Sub-involution is one of the most common as well as one of the most serious diseases that afflict women. Until a few years ago this disease was considered the most difficult to successfully treat of all morbid conditions of the uterus. This was so because no clear understanding of the condition of the organ had been obtained, or, if so, no remedy had previously been found that would remove the engorgement. In treating this condition the old-timers depend upon general treatment, tonics, depletion by leeching, scarification, cupping, cauterizing, counter-irritation, emollient vaginal injections, alteratives, abdominal bandages, and pessaries, often causing more suffering and a worse condition than if nothing had been attempted but to let nature take its course. Many homœopaths, we regret to say, adopted the same heroic course of treatment pursued by the old-timers, because they could not always select the internal remedy to remove the condition. Unless remedies are administered homœopathically, to meet the symptoms as they appear from the incipency of the disease, internal medication has been of little service in the treatment of sub-involution.

In this disease there are three stages, viz : Congestion, inflammation and hyperplasia, each progressive ; the first merging into the second and the second merging into the third. The first, which in about every case is caused by injury, may be relieved at the commencement by the indicated homœopathic remedy. The second stage, inflammation, may also be relieved so that the third stage may not appear, but after its appearance there can be but one way (except, that, sometimes, in a very few cases, perhaps one in a thousand) to successfully treat it, and that is to remove the engorgement. As before stated, sub-involution is caused in the first place by an injury of some kind : running sewing-machines, jumping, dancing, falling, lifting, straining, during or immediately after the menses, when the organ and appendages are all relaxed and more susceptible than at any other time to traumatic influences ; or improper care or neglect (getting up and working too soon) after childbirth, abortion, or miscarriage, injections of cold water immediately after coition, and various other irregularities or indiscretions, or indeed the commission of any act on the part of woman, not in accord with nature or nature's laws, will cause injury to the womb or its appendages. Any act of this character is liable to, and most generally does, result in congestion, to a more or less degree, which is quickly followed by inflammation, for nature will send all the blood possible to the injured part. If one injures a finger by a cut or bruise, or sprains an ankle, nature sends all the blood necessary to the part, and in consequence it soon after becomes swollen and tender. This is congestion followed by inflammation. So with the uterus. All the blood sent to the uterus in consequence of an injury or of an injection of cold water, when the part is over-heated, does not, on account of the peculiar interstitial formation of the tubular glands and cells of which the middle or muscular layer of the substance of the uterus is composed, return into circulation, but is retained in the uterine walls, and the inflam-

matory condition ensuing changes it into serum. This cannot be re-absorbed, but is increased until it fills the interstices, and the uterine walls are thickened and hardened, so that the organ has grown so large and so heavy that the ligaments which hold it in place are no longer able to support it, and it must necessarily drag down or turn to one side, forward or back. Indeed, it becomes so large that it cannot remain in the space provided for it by nature, and the intestines above, the bladder in front, and the rectum behind, force it into the cavity of the pelvis. Then the patient complains of headache, backache, pains in the pelvis, dragging sensation about the loins, bearing down pains, leucorrhœa, menstrual disorders, throbbing about the uterus, general feeling of fatigue, malaria, weakness, dispondency, constipation, irritability about the bladder and rectum, some one or more, or all of these symptoms may be expected to exist in every case. On examination there is found to exist prolapsus of the uterus, retroflexion or antelexion; it is enlarged and tender; there is more or less leucorrhœa; the os is open and often the cervix is found to be red and inflamed, and sometimes granulated.

No woman thus affected feels perfectly well, nor can they be well, although they may look well in the face and may perform or attempt to perform their daily household duty. No woman thus affected can afford to neglect treatment, for if the affection is allowed to continue, in nine cases out of ten it will result in producing some complication, such as cystitis, rectitis, cellulitis, endometritis, dyspepsia, hysteria, mania, epilepsy, insanity, tumor, epithelioma, or fibroid of the uterus, ovaries, or mammary glands.

To cure this disease, as before remarked, the engorgement must be removed. The interstices and tubular glands and cells must be emptied of the serum which is constantly accumulating and overflowing, in the form of leucorrhœa, as long as the sub-involution exists. This can be done by the application of the elaterium or the squirting cucumber.

The attention of the writer was first called to the usefulness of elaterium while compiling the Concordance Repertory from the *Materia Medica* nine or ten years ago. Cowperthwaite, in his general analysis of the drug, says that it "acts powerfully upon mucous surfaces, causing an enormous flow of watery serum from the first mucous membrane that absorbs it." We reasoned, if elaterium produces that effect it would be the very thing to remove engorgements of the uterus. But we found on further investigation in the *Materia Medica*, that elaterium is the most active and certain of known hydrogogue cathartics; causing colic, nausea, vomiting, prostration, and sometimes collapse. We feared to use the drug on this account, but after reflection concluded that it could be prepared by graduation so that it would produce the flow of serum without causing any of the dangerous or unpleasant effects upon the system. We procured one grain of elaterium and mixed it in the mortar with ten grains of sugar of milk, and then mixed it with one drachm each of glycerine, lard and cocoa-butter, and consolidated by a gentle heat. There was a case of sub-involution which we had been treating for some time according to the old method of applying iodine, glycerine, hydrastis, etc., without any prospect of improvement. The patient was a great sufferer from backache; headache; dragging, heavy, bearing-down sensation in the sacrum; constipation and profuse leucorrhœa. We determined to apply the elaterium as prepared, which was done by introducing a bolus about the size of a common playing marble into the vagina and smearing it over and about the cervix. The next morning we were called upon to visit the patient, as she was unable, on account of some obstruction about the meatus urinarius, to pass water. The obstruction was found to be a hardened substance or exfoliation something like the membrane adhering to the shell of a hard-boiled egg. It adhered tightly to the membrane about the meatus, clitoris and labia, and required some force to remove it.

The same membrane, but not so tough, was found adhering to the vaginal walls, which, when removed gave an exact mold of the vagina, cervix, os, and cul-de-sac. One would have supposed that the medicine had cooked and destroyed the mucous membrane of the parts, and it had come away leaving the vaginal walls like a raw piece of meat, but on examination the membrane was found intact, and as clean as could be. We then applied a weak solution of hydrastis, and left the patient comfortable. On visiting her the next day, we found more of the pseudo-membrane, which showed that the elaterium had not completed its work when the former attachment was removed. This additional collection was removed and more solution of hydrastis applied. The following day (the third), we found patient feeling much better in every way than she had felt for months, and was encouraged to make another application of the elaterium, which we did, and, this time, anointed the meatus and surrounding parts with vaseline to prevent adhesion of the exudation. The application resulted the same as before, except the annoyance about the occlusion of the meatus. The vaseline prevented it. The exfoliation was removed the second day by injection of a large quantity of warm water, followed by the hydrastis.

The patient continued to improve, and the treatment was continued every three or four days for a few weeks, until she was entirely well.

Since then we have used the elaterium in every case with the best results.

At the meeting of the American Institute, at Niagara Falls, in 1888, we had the pleasure of presenting the foregoing facts regarding elaterium to the profession. Many have used it and with satisfactory results. Some, however, not understanding that the exfoliation was the coagulated serum, thought that the application had destroyed the mucous membrane, and were so frightened that they would not again use the remedy.

There is something remarkably singular and unaccountable regarding the action of the elaterium in producing such a great flow of serum, and causing it to coagulate in the vagina. We believe it is the only drug which has this power.

In using it we have found patients so susceptible to the action of the elaterium, that it would make them very weak and sick, and we had to greatly reduce the power of the application by using a smaller quantity of the drug in the vehicle, or a larger quantity of the vehicle. In some cases the application would have but little or no effect unless more of the drug was used.

For the past year we have been using the tincture of the elaterium, one part of the remedy to nine parts of glycerine, and after saturating a large pledget of absorbent wool with pure glycerine, then dropping about twenty minims of the elaterium and glycerine mixture on the wool, and by thoroughly manipulating the wool in the hand, distribute the remedy through the wool, and introducing it into the vagina. We find in this way the coagulated serum attaches to the wool, and is removed with it. A string should be looped around the middle of the wool, so patient can remove it before presenting herself for another treatment.

POSTSCRIPT.—Since writing the above, several months since. I thought of the plan of using elaterin, instead of the elaterium, and solicited the assistance of Messrs. Parke, Davis & Co., the manufacturing druggists, of Detroit, Mich. They made a very elegant suppository for me, containing one-sixteenth of a grain of elaterium to one drachm of glycerine, and I have been using this suppository in practice since. With this application there is no exfoliation, but a gentle flow of serum is established, which with an occasional application of a suppository is kept up until the engorgement has disappeared.

In one case where I used this elaterin suppository, six weeks since, the lady, aged forty-five, had suffered for four years, or

since the birth of her last child. Her abdomen was very large and she was generally œdematous. Suffered with backache, headache, and insomnia. One application of the elaterin caused a profuse flow, whereas she had never had any discharge of leucorrhœa. That discharge continued without another application for three weeks, when I applied another. She is now without any œdematous appearance ; her abdomen is notably reduced, and on examination I find the uterus, which was as large as a large-sized egg-plant, and about as hard, six weeks ago, is reduced more than one-half. She has been free from backache, and nearly free from headache for three weeks. She also sleeps well.

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### COMMONPLACE MIDWIFERY.

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BY

GEORGE WILLIAM WINTERBURN, M.D.,

NEW YORK.

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*(Continued from page 28.)*

I never thank any one for delaying sending for me until near the end of the first stage. The mental and moral condition of the woman during the first stage presages the physical difficulties of the second, and to be a witness of these is to be forewarned of dangers to come. Most cases of labor would terminate favorably without the presence of the physician. If in such normal cases we find waiting tedious, it is our duty to remember that our real value is small, and our influence chiefly a moral one. If, however, we are really needed, that is, have any higher work to do than falls within the compass of an ordinary midwife, the time to do it is in the first stage, when false positions can be rectified, and the ease and safety of labor promoted. I am speaking now to homœopathic physicians, strong in the faith because able to transmute faith into works. I am aware that it is inadvisable to display much enthusiasm



over the dynamic forces of medicine in a homœopathic medical society. The chilling atmosphere of disbelief when any remarkable success is alleged in those cases that trench upon the domain of surgery—as for instance, the cure of a cartilaginous stricture—is in marked contrast with the interest taken in a new curette, or an axis-traction forcep.

During the first stage one can do so much by attention to the arrangement of the bed, of the infant's clothes, and the other minor auxiliaries and paraphernalia of labor, to establish that confidence and mutual sympathy which should exist between the woman and her doctor, that to miss this opportunity is to sacrifice half our usefulness.

If turning is necessary now is the time to do it, by external manipulation. If there is one invariable aphorism in obstetrics it is *turn early*, before the thinning of the lower segment of the uterus makes it dangerous.

**THE SECOND STAGE.**—At the beginning of the second stage voluntary effort, on the part of the woman, is usually needed or else the progress of labor will be slow, while toward the end this should be moderated, in order to avoid the too rapid descent of the foetus. Therefore, at the beginning of this stage I command quiet on the part of the patient, with the greatest possible effort during pains and complete muscular laxness between them; but as the head approaches the perineum I encourage her to cry out, as this prevents the diaphragm being used as a fulcrum, and leaves the work to involuntary action. This gives the vagina and perineum time to stretch, and often prevents rupture.

As a *partus accelerator* I have used *ustilago maidis* quite extensively; probably in 70 or 80 cases; but not frequently in later years. It hastened delivery, but like *ergot*, though to a less extent, increases the painfulness of the “after-pains.” In using it, I put a teaspoonful of the fluid extract into half a goblet of water, and of this mixture give a teaspoonful every five minutes, more or less, *pro re nata*. The

usual effect is an entire cessation of the pains for twenty minutes or a half-hour, when they return in full vigor. In a small minority of cases it will do good; but doubtless I used it in many cases which would have done equally well or better without it. It is better, both for mother and child, that the labor should last an hour or so longer, than that it should be abbreviated by that much, and the woman suffer from severe after-pains for two or three days.

During the second stage I use the bi-sulphate of quinine freely. Not in all cases, very rarely in cases which I have had opportunity to overlook during the previous months, though even here sometimes a few grains does good. Cinchona has no direct influence on uterine fiber; it is not a parturifacient, but given in small, repeated doses it will change a delaying, painful, inefficient labor into a normal one. My obstetrical practice has been largely among the poor of the sixteenth and twentieth wards, mainly among that class whose only crime is poverty, and who, amid uncouth and somber surroundings, often reveal a refinement of feeling and appreciation of moral excellence, which has aroused within me the deepest sentiment of brotherhood and solidarity. In such households, if the occupancy of two or three mean little rooms deserves so grand a designation, the mother often comes to bed in a half-starved state, because the brood of little ones about her must not go unsatisfied. To such a woman, burdened in body and yet more in mind, quinine in doses of one or two grains every five or ten minutes until twelve or fifteen grains have been taken, will bring courage and buoyancy, and for the nonce make life seem worth living. I am in the habit of supplying myself with a quantity of these pills, and feeding them to the patient one by one. I call them my "courage pills," and whether it is the kindly sympathy with which they are given, or whether it is my confidence in their utility, or whether it really is the virtue of the drug, I know not, only I know the response is often magical. The whining, fret-

ful, despairing mood passes, and the woman braces up and has her baby in good style.

Through the courtesy of the late Mr. Robbins, of McKesson & Robbins, I had the opportunity of experimenting, some ten or eleven years ago, with a large number of the salts of quinine.

I was furnished with upwards of a hundred specimens, many of them made for the first time, and most of them proving to be mere chemical curiosities. My desire was to find a salt which would strike the happy mean between deliquescence and stability. Nothing was produced which, on the whole, for cheapness, reliability, and prompt action is superior to the bi-sulphate. This salt, while absolutely stable under all atmospheric conditions, is more readily dissolvable in saliva and the gastric juices than any other that is not acted upon by moisture in the air. As the result of numerous trials it was definitely ascertained that when the mucous surfaces were in a normal condition the physiological effects were perceived within five or six minutes after ingestion.

Lard is a most useful adjunct in the lying-in chamber, and I always use it when I can get it; but, as I have a brother-in-law in the business who says it cost him fifty thousand dollars to learn how to make a prime article so as to be able to sell it for less than the cost of the leaf, I am rather particular as the quality of the lard I use. If I can do so I have the leaf purchased at the hog butcher's, and tried out at home. Then we have an article which, for obstetrical use, is superior to anything in the line of grease—lanolin, vaseline, olive oil, or what not.

Having secured a good article I use it freely; occasionally a couple of pounds in the conduct of a case. Nothing produces such a cooling effect on the heated membrane of the vagina as a good coating of lard. It requires some dexterity to carry a chunk of lard the size of a hen's egg up into the vagina without leaving the best share of it outside

the vulva, and smeared on the bed-clothes; but when once the knack is acquired we have at our command an unequaled accelerator of parturition. It is well known that lard applied to an inflamed tissue, dermal or mucous, not only reduces the local inflammation, but the systemic temperature as well, and in obstetric work I have seen its application, as I have described, in many instances so quiet nervous tension as to reduce the pulse-rate five or ten beats, in as many minutes. Carrying small pieces the size of an almond well within the os, and rubbing it thoroughly into the tissues, not only breaks down moderate rigidity, but prevents tearing of the cervix by making the muscular fibers more elastic. Lard has great penetrating power, and when used early and often, it will increase the elasticity of the perineum and prevent rupture. I ascribe the infrequency of this complication in obstetrical cases, in my experience, to leaving the perineum alone, and the free use of lard. If you take care of the presenting part, the perineum will take care of itself; and if you use lard early enough and unstintedly enough you give it the best aid in your power.

In the matter of rupture of the perineum the personal equation of the accoucheur counts for much. I know a surgeon of New York, of large experience and much culture, who confided to a fellow-practitioner, not so very long ago, that he had never seen a truly natural case of labor in all his round of experience. Another surgeon, resident these many years in Brooklyn, widely known and highly honored in that community, told me a couple of years ago, in reply to an inquiry of mine as to the frequency of rupture of the perineum in his practice, that rupture occurred in a majority of cases, and in primipara always. Another popular accoucheur, a member of this society, whose daily experience includes a case of obstetrics, that is, who has for years averaged more than 365 cases a year, answered the same inquiry by the assertion that rupture occurred so rarely that

it might almost be said to be unknown. Evidently these men differ in the management of their cases.

The consensus of authoritative opinion seems to indicate that perineal laceration is unavoidable in about fifteen per centum of all cases, not including slight tears confined to the frenulum; but with the free use of lard, and lifting the child's head upward and forward, while at the same time preventing the too rapid descent of the body by requiring the woman to breathe deeply during a pain, nearly all of these accidents may be avoided. If, nevertheless, the tension is so great that rupture seems imminent, by having the nurse draw the perineum forward it may be saved intact. This maneuver is best accomplished by inserting two fingers into the anus, with the palmar surface of the hand lying in the same plane as the posterior wall of the perineum. Episiotomy I have never practiced, and I believe with Lusk that it is essentially the operation of young practitioners; and I didn't hear of it soon enough. The same may be said of incisions through the vaginal portion of the cervix.

When the mucous surface of the vagina is abraded or torn, I use a weak decoction of calendula flowers, at a temperature slightly above that of the body ( $100^{\circ}$ – $105^{\circ}$  Fahr.). Care must be exercised not to have it too strong, just giving forth a faint odor of the flowers, or frightful œdema of the parts may occur. I have used carbolized, thymolized, and chloridized washes, but I come back every time to calendula as the most satisfactory in every way; though for a cleansing wash I sometimes use sulphate of copper, in the ratio of one to a hundred, at a temperature of  $120^{\circ}$  Fahr., or thereabouts. It is antiseptic, astringent, coagulates albumen, and thus stops bleeding from any small arterial twigs which could not be reached easily otherwise.

**ANÆSTHETICS.**—I have used various anæsthetics, mainly chloroform, ether, and a combination of the two with alcohol; and, on the whole, I prefer chloroform, and now use

this altogether when I require anything of that nature. I have passed through three phases in regard to chloroform. At first I was afraid of it, and did not use it even sometimes when I would have liked. Then when I began to use it I gradually became enthusiastic about it, and used it in almost every case, not usually to the point of complete anæsthesia, but dulling the sense, and often, I fear, prolonging the labor. It was not long, however, before it dawned upon me that this was senseless practice; that the pain was physiological as well as the labor; and that morbid pain in labor could be controlled homœopathically, if the doctor knew how to do it. I, therefore, began to study, for this particular use, such drugs as valerian, zincum, cimicifuga, ignatia, coffea, aconite, chamomilla, caulophyllum, and the like. I have not abolished pain in my cases, however. Nor am I altogether sure that I would do so if I could; pain has its uses as well as adversity; but intolerable pain, morbid pain, whether the morbosity be in the mind or in the muscle, may be made tolerable and physiological.

I have never used cocaine in the vagina, as some do, for the same reason that I now rarely use chloroform; but I have tried one expedient which acts admirably if the woman can be induced to persist in it. That is deep and rapid breathing. This will produce a form of narcosis, sufficient to dull the severest pain, and yet has none of the disadvantages of drug-anæsthesia; but women rarely have persistency of purpose to keep it up continuously enough to receive the full benefit. This form of treatment is best adapted to those women who do everything *pugnis et calcibus*, or to such who are easily controlled by the operator's will. Hypnotism offers an encouraging field in this latter class.

RIGID OS UTERI.—I was once completely baffled by a headstrong and rebellious os; I could neither coax it nor drive it. After having lubricated it with lard without the slightest effect on its persistent rigidity, doused it with hot

water, tried chloroform to the point of anæsthesia, tried gelsemium until the patient thought she saw two of me, tried just sitting still and doing nothing, until at last I made up my mind that I was ignominiously beaten, and sent for good old Prof. Burdick. The os was dilated to somewhere about two inches and a half across, was as thick as my finger, and as hard as a piece of steel. When Burdick came I told him the whole story, and he sat there and looked at me, and then at her, and back at me, for about three minutes. What was my surprise then to have him ask for my forceps and begin to apply them. This was a difficult feat, and quite beyond me at that time; and, indeed, I remember it made great beads of perspiration stand out on his forehead. But once applied, steady traction for ten or fifteen minutes took all the obstinateness and pluck out of that bit of tissue, and thenceforth the labor progressed satisfactorily.

Of late years I have adopted the plan of rimming the os, the only objection to which is that it is exceedingly fatiguing to the accoucheur, in a persistent case. Seated on the edge of the bed I insert a finger past the first phalange into the os, curling it so as to catch the inner surface as by a hook, and begin slowly to make it travel about the edge, applying considerable pressure. The amount of pressure is not of so much importance as the evenness and steadiness with which it is applied. To keep this up for fifteen minutes requires a large amount of pluck and endurance. I used to get tired, and, abandoning it after a few minutes, try a hot water douche, and if that did not answer, then sensible doses of gelsemium; but now I get tired and go right on, though sometimes the finger will be numb for a space of two days thereafter. I have used the Molesworth dilator, which is easy to apply, but then there is always uncertainty as to what it is doing. The fact is, the only obstetrical instrument I have any fondness for is the human hand. I have, for this purpose fortunately, a small and very

flexible hand, and wherever I can get that I prefer it to all the curettes, forceps, and dilators that ever were made.

**FORCEPS.**—I have used the forceps 47 times in my own cases, and 17 times in consultation. They are a great temptation when one is tired and sleepy and wants to go home and to bed. I put temptation, in more recent years, as far from me as possible by leaving my forceps at home, and only sending for them when their usefulness to mother or child is made manifest. When I first owned a set I was quite proud of them, and lugged them around everywhere, rather glad of an excuse to use them, and sillily proud of myself when I had yanked a child into the world an hour before his time.

I bought soon after graduation a set of Burdick's, and have never had occasion to use any other. One can do better work with an accustomed tool than with another, and nothing is gained by trying first one pattern and then a different, if the choice has been well made at first. I have read much of what has been written as to axis-traction, and have examined Tarnier's instrument, and Simpson's and Lusk's modifications, with interest. The theory is excellent; but I am inclined to think that as a matter of practice it will never come into general use. If I were doing now as much obstetrical work as I did once, and had available as capable assistants as I had then, I should certainly use Lusk's Tarnier sufficiently to have a right to an individual opinion; which I have not now.

Embryotomic deliveries I have taken part in, but never as principal; but the impression left upon my mind by what I have seen, what I have heard, and what I have read, is that the necessity for them mostly lies in want of prevision. The idea that is in my mind is well expressed by one who has a right to be heard on this or any question in midwifery: "By the general substitution of methods of delivery compatible with the safety of *both* mother and child, the propor-



tion of cases in which embryotomic instruments are employed has been so minimized as to lead to a confident expectation that all such implements as the craniotomy forceps, the perforator, the cephalotribe will be relegated from the obstetrical armamentum, to the chamber of horrors of some future museum of surgical instruments. At any rate, from the progress recently made in this respect, we have reason to look forward to a not distant day when the great objects of obstetrical science, the delivery of a living child with safety to its mother, may in nearly every instance be secured." <sup>11</sup>

**TYING THE CORD.**—My practice is to tie the cord after it has become pulseless; tying twice and severing between the two; that on the placental side partly for cleanliness, but more for the purpose of keeping the placenta as large as possible—the fuller it is the less elastic it becomes, and so the more easily is detachable. In dressing the umbilical stump of the cord I untie the knot, so as to permit the retained blood to outflow, strip off the jelly of Warton, and then retie. This procedure lessens the size of the stump, and encourages dry gangrene. Since doing this I have had no trouble with it in any case.

Budin,<sup>12</sup> in 1875, instituted an inquiry as to the amount of blood lost in severing the cord, by comparing the quantity which flowed from the placental end when the cord was divided immediately on the birth of the child, with that which escaped when the cord was not cut until the delivery of the placenta. The result of careful weighing, in a long series of cases, was that this difference averaged three ounces. Schücking,<sup>13</sup> two years later (1877) corroborated these results. Zweifel,<sup>14</sup> in the following year, in a series of

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<sup>11</sup> Thomas More Madden, M.D.

<sup>12</sup> *Bulletin Therapie.* 15. ii. 1876.

<sup>13</sup> *Berlin Klinik Wochenschrift.* Nos. 1 and 2. 1877.

<sup>14</sup> *Centralblatt für Gynäkologie.* I. 78. 1879.

one hundred cases, found that the difference in the amount of blood loss between immediate cutting of the cord and delaying until the placenta was expelled by Credé's method was three and a half ounces. Hofmeier,<sup>15</sup> in 1879, varied the experiment by weighing the child immediately after birth, and again on the tenth day. In 90 cases, in 40 of which the cord was cut early, and in 50 late, the loss of bodily weight was much less in the latter than in the former. Porak energetically combated these several assertions, and claimed that vomiting, jaundice, and other ills followed late cutting of the cord; that the loss of blood was beneficial rather than otherwise, and that infants usually suffered from plethora; but his views are not sustained by general experience. Engel,<sup>16</sup> the last prominent man, who has written on this subject, as far as I am aware, claims that even trivial losses of blood are serious, and that in those children in which it is limited to a minimum, it will be noticed that they are rosier, cry less, sleep better, and are later in demanding to be suckled; all these things must be beneficial not only to the child but to the mother also. But Engel claims a still more important advantage from late severance of the cord; namely, that it has a weighty influence on vitality, especially in infants prematurely born. Of these, during four years when he tied the cord immediately on delivery, he had 90 cases of premature birth in his clinic of these 17 died (18.88 per cent.); in the following four years, when he delayed tying the cord until all circulation through it had ceased, he had 74 premature cases, of which seven died (9.45 per cent.). He claims that in other respects the treatment was the same, and that the lessened mortality was secured solely by late ligature of the cord.

The amount of blood saved to the child, by late ligature, is thus equal to from one-fourth to one-third of the entire amount in its system; stated in this way no one can doubt

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<sup>15</sup> *Zeitschrift für Geb. und Gynaek.* Bd. iv. 1879.

<sup>16</sup> G. von Engel. *Centralblatt für Gynäkologie.* Nos. 46. 14. xi. 1885.

the value of late ligation. Yet I know doctors who do not tie the stump at all, just let it bleed until it stops. At least they say they do.

The circulation in the cord ceases sometimes as soon as the child is born, but in cases otherwise normal this is extremely rare. Schroeder has seen the pulsation still continuing after a lapse of fifteen minutes. He says: "If an umbilical artery and vein be cut across during this continuance of pulsation, it will be observed that while the contents of the former are expelled by successive jerks, those of the latter flow out in a continuous stream. Further, it can be seen that the blood ceases to flow from the artery sooner than it does from the vein." The reason for this longer continuance of circulation in the vein would seem to me to be that the artery contracts under the influence of cold, while the vein is much less susceptible, and cannot contract as the artery does. If the cord is kept warm by wrapping it in hot flannel the circulation may be maintained much longer; this applies, of course, to the uncut cord.

The transfusion of blood from the placenta to the child is thus seen to be dependent on inter-uterine action to some extent; though, in fact, vascular contractility plays but a subsidiary rôle in this phenomenon. The transfusion is mainly due to aspiration, the first deep inhalation of air into the lungs accomplishing often the major part of this transfer. Thus in the German experiments, when the cord was cut the instant the body emerged and before breathing commenced the blood-loss was three ounces or more, while in Dr. Brakenall's experiments, at the Sloane Maternity, where the cord was severed after breathing was established but before the cord had ceased to pulsate, the amount of blood lost was from an ounce to an ounce and a half. Thus cardiac action and vascular contractility form the two opposing forces upon the combined effect of which depends the possibility and quantity of arterial transfusion from the fast dying placenta to the revived child.

Since my attention was directed to Hofmeier's experiments I have used most strenuous endeavors to preserve to the child every possible drop of blood. In only one instance has a child born alive perished during its first month. Often and often multiparous mothers have said to me how much better, or stronger, this child was than former ones, in which presumably some other method may have been pursued. This reinforces what is said by Engel.

THE PLACENTA.—If I do not misread current literature, the opinion of the day favors a somewhat extended interval between the birth of the child and the delivery of the placenta. Playfair voices this by picturing the latter as a miniature of the former, and indicates half an hour as a usual and proper interval between the two; strongly reprehending a quick delivery of the placenta as likely to cause hæmorrhage, inversion, or some similarly untoward result. In this respect, however, the English school is far behind the modern German; as will be seen from the following summary of a method enunciated by Ahlfield, of Leipsic, about a year ago, and entitled "Expectant Method, or *Credé Manipulation*." <sup>11</sup> Ahlfield's argument is elaborate, but the substance of it is this: After the delivery of the child and division of the cord, the external genitals are cleansed with sublimated or carbolized cloths. At intervals of five minutes the parts are to be inspected, so that the progress of the case may be known, and hæmorrhage checked if it occur. If after waiting an hour and a half the placenta has not been extruded by natural evolution, the urine is to be drawn, and the secundines expressed by the usual manipulation. If, during the period of expectancy, bleeding is discovered it should be arrested by massage; but if this fails, and the amount of blood-loss seems serious, then the uterus is to be emptied as quickly as possible. Winckel, Dohrn, and a host of major and minor stars in the obstetric field,

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<sup>11</sup> *American Journal of Obstetrics*, Nov. 1888.

announce their allegiance to the doctrine of expectancy, and the satellites are falling into line, with a sublimated rag in one hand and a five-minute glass in the other; but presently the wheel of Ixion will revolve, and Science will be delivered of a new opinion.

In my salad days I always proceeded to the delivery of the placenta with caution and deliberation; but in 1879 I made a complete change in my method. I now deliver the placenta as quickly as possible. I will state the method briefly. Unless there is obvious reason for haste, I delay the last act in the second stage of labor, by pushing back the advancing head during two or more pains, so that when the head does begin to pass the vulva the operation is quickly accomplished, and with one more effort delivery is complete. Now, turning the child over on its back, I announce the sex, and tickling it under the arms, set up reflex action, and vigorous respiration. Many infants will give two or three feeble cries, and then doze off; this I do not permit. To secure the greatest dilatation of the lungs in that first critical moment is my constant endeavor. I am in no haste to tie the cord, and do so only after the child has had several minutes of squalling, which I cordially encourage. Nothing is more soothing to a mother's ear than the cry of a new-born child; and thus, in this first half-automatic act of the new-born is subserved two useful purposes, and thus begins, with the earliest moment of separated life, the weaving of that cord of dual beneficence which binds mother and child more strongly than the prenatal fleshly tie.

The cord severed, the babe wrapped in a blanket and laid aside, I at once proceed to the removal of the secundines. With the left hand I outline the collapsed womb. If it is ovoid in shape, the placenta is yet within it, and pulling on the cord would possibly do mischief. But if the uterus is round it is empty, and then, encouraging the woman to make a sneezing effort two or three times, with the right hand I

seize the presenting edge of the placenta and dexterously bring it into the world, rotating it slowly so as to gather together all the membranous shreds which are hanging to it. This operation rarely takes more than three minutes, is never followed by hæmorrhage, causes hardly any pain as the parts have not yet recovered from the numbness produced by the pressure upon them of the child's head, and relieves the nervous tension under which the woman must remain until she knows this final act in the drama of travail is complete. Thus in eight to twelve minutes after the birth of the child, the after-birth is on its way to the kitchen range, the mother is lying well-wrapped and at ease, and the doctor and nurse are at liberty to turn their attention to this youngest candidate for citizenship.

If the placenta, however, has not descended into the vagina during the time preliminary to the cutting of the cord, a somewhat different procedure is necessary. Slapping the back of my right hand into a saucer of lard which is standing within convenient reach, I draw it into cone-shape, by pressing the tips of the fingers together, so that each touches each. I pass it up, in this shape, within the os, and grasp the placenta firmly with the tips of two or more fingers, while at the same time I gently manipulate, with the left hand, the uterus, through the abdominal walls. I say manipulate, but the action really is a gentle stroking of the uterus, from above downward, and from side to side, much as one would stroke a cat's back, only with a firmer touch. Doubtless the ability to give off magnetism, by concentration of will-force, has much to do with the success of this maneuver, for in two or three minutes, while exerting traction (not on the cord but on the presenting edge of the placenta) little more than necessary to overcome the actual weight of the placenta and its membranes, these begin to slide down toward the vulva, and the uterus contracts solidly down upon itself.

I always note the time of the babe's first cry, and also the

time when I have washed my hands after depositing the secundines in the vessel appointed to receive them. The interval is often not more than ten minutes, rarely fifteen, and even in the most difficult cases has never, to the best of my recollection, exceeded twenty, in my last three hundred confinements. Doubtless when one acts in accordance with a well thought-out rule of procedure, the mere attention to routine suppresses emotion ; but really the delivery of the placenta causes me no more anxiety than the dressing of the stump of the cord, or the pinning of the maternal bandage.

A brief digression will explain the mechanism of placental delivery. In a perfectly normal labor the moment succeeding the passage of the child into the world is one of extreme relaxation of all the parts. The placenta still being adherent there is no hæmorrhage, and the uterus can be felt in a flabby condition, extending upward above the umbilicus, and apparently nine or ten inches long, and three or four broad. In this relaxed condition it is often difficult to find if the omentum is at all large, and when made out feels for all the world like a piece of bowel. If the case is left to itself this condition may continue for some time, perhaps even extending into hours, and without danger, as the uterus is completely full, and hæmorrhage cannot occur until the placenta begins to peel off, which it will not do until by contraction of the uterine walls the placental site is reduced to an area of four and a half square inches. It is a common error to suppose that there is a uterine cavity, a space unoccupied, after the birth of the child. This is not so. A diagram, produced by Stratz,<sup>18</sup> shows a frozen section through the uterus of a woman who died at the termination of the second stage. This uterus, which is ten inches in length by about three and a half in thickness, is everywhere in close contact with the retained placenta, the

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<sup>18</sup> "The Sectional Anatomy of Labor," by A. H. Freeland Barbour, M.D. *Edinburgh Medical Journal*, October, 1887, page 320.

uterine walls following the sinuosities of its surface. This is believed to be a fair representation of things as they exist normally at the beginning of the third stage. With this state, of a foreign substance capsuled within the uterus, we may have hæmorrhage, or we may not; the mere mechanical retention of the placenta is certainly not a source of hæmorrhage, but indeed rather the reverse.

Now I think we have here the testimony of nature as to the place and scope of homœopathic medication in uterine hæmorrhage. Why is it with the placenta entirely detached and retained in the uterus we have no hæmorrhage, while with only a partial detachment we often have severe blood-loss? That is, with a part of the uterine vessels torn across there is considerable bleeding, but in another case with all of them ruptured we have no bleeding. In both cases the uterine cavity is acknowledged to be approximately equal to the placental mass; for the best observers are agreed that practically there is no empty space, the uterine walls and the placenta everywhere touch unless forced apart by clots, the entering hand, or other foreign substance. It would seem that the difference between the two cases is a pathological one; the adherency and the bleeding are two expressions of one fact. This being so, our answer should be the remedy homœopathic to the case, and our ability to prescribe that is the measure of our knowledge.

Circulation having stopped in the placenta, that organ hardens by the congelation of the blood within it, and acting as an irritant in the womb, causes contraction; the ensuing diminution of the placental site, a diminution to which the placenta cannot accommodate itself, causes separation, and the downward push of the descending fundus the extrusion of the placental mass and of any clots which may have been formed. If a severe pain can be induced the detachment takes place in one effort, but when the pains are feeble the detachment is partial. If partial it



most usually begins in the center, and as the uterus again relaxes the blood is aspirated into the hollow between the uterine wall and the placenta ; in this cavity thrombi form, which block up the vascular mouths, and prevent excessive bleeding. Traction on the cord will cause bulging at the center, and will increase the probability of this form of separation. If the separation occurs at the upper edge the hæmorrhage will be dammed in by the body of the placenta, and thus held in check. It is only when the separation is from below that dangerous hæmorrhage can occur ; and the firmer and more extensive the adhesion above may be, the greater the risk. Flooding cannot occur while the placenta remains completely attached to the uterus, and can only become dangerous when relaxation after a pain leaves the upper portion adherent and the lower hanging free. Hæmorrhage is not probable when the placenta is completely detached and retained, as this then acts as a tampon, the healthy uterus rarely relaxing more than just sufficient to keep its parieties in contact with the placental mass.

The cause of the non-separation of the placenta depends on the defective development, or pathological condition, of the spongy layer, or of the mesh-work layer. The patient has probably had an endometritis. In all cases which I have had a previous history of uterine inflammation could be traced.

Now what shall we do with these cases? Winckel, of Leipsic, counsels expectancy ; but after two hours would proceed to deliver manually. This may be taken as a fair index of the most enlightened old-school practice of the day. Has homœopathy anything better to offer? I think it has. The difficulty is to find the key-note for the remedy ; but why should this be more difficult here than in an impending abortion, or in Asiatic cholera? We know we can cure these by homœopathic medication, why not the former? Lilienthal mentions ten or a dozen drugs for this condition, but I know of no reason for limiting the selection

to these. My own experience covers but half a dozen cases, only two of which were really serious, and each of these was apparently benefited by a remedy in Lilienthal's list; but, while I was then, and am now, ready to defend my action in these cases as truly scientific, I am not sure that anybody else here present will think so.

The first of these cases was in August, 1883. The patient, 4-para, was the wife of the janitor of an apartment house, situate on Thirty-third Street. The labor was uneventful and rather brief, the second stage lasting less than two hours. The child was a well-developed male, weighing seven pounds six ounces. On proceeding to the delivery of the placenta in my usual way, I found that while I could induce fairly strong pains, the placenta did not move, and as during the relaxations there was no hæmorrhage, it was evident that the placenta remained attached over the whole site. Had there been detachment in the center there might have been no visible hæmorrhage, but the uterus would have become globular; as it was it remained about twice as long as it was thick, and during a remission could be felt just above the umbilicus. The question now arose, should I attempt to peel it off digitally, or wait? The most experienced obstetricians state that in peeling off the placenta, in these cases of firm attachment, the division is apt to occur in the plane of the juncture between the mesh-work layer and the spongy layer. That is, the foetal placenta and the membranes come away, leaving the maternal placenta behind. Thus the uterus is lined with a layer of dead tissue, and we all know what that means. Sometimes when force is used the whole placental mass comes away, bringing with it the superficial surface of muscle. Now if this is what occurs in large maternities, where they have a constant succession of difficult cases, and where they have appliances to meet all emergencies, and fresh attendants to replace tired ones, what is the ordinary practitioner to do, alone, in a dark basement bedroom? I can testify as to what one

practitioner did—he sat down and waited—but as he sat waiting he asked himself, What remedy is homœopathic to this case? The woman was a tall blonde; easy, good-natured disposition; had a history of considerable uterine trouble, and had probably had endometritis about two years previously, following a miscarriage. The only clinical symptoms which could be elicited were these: the pains, though not extremely severe, were long lasting, and did not seem to involve the whole uterus equally; they made her feel faint, but the faintness was not accompanied by unusual pallor; there was a slight dyspnœa, and demand for fresh air, but this may not have been a clinical symptom, as the weather was warm, and the patient confined in a room whose floor was several feet below the grade. No remedy seemed so likely to be helpful as *pulsatilla*, which was given in the thirtieth potency. Its first apparent effect was to put an end to the pains. In less than an hour the patient was sound asleep, and, it then being after the breakfast hour, I returned to my own house, leaving word to be sent for if the pains returned. At noon I saw the patient. She had had a long and refreshing nap, was feeling comfortable, no pains; *pulsatilla* continued. Thus everything remained, no hæmorrhage, no pains, for fifty-six hours. The patient, and her family, became very dissatisfied, and even if they had not been I should have been in no enviable mood. I knew it was best to wait, I believed nature was, with the help of *pulsatilla*, working out her own salvation; but I also realized that if anything did finally go wrong I would be severely censured, that I had the consensus of professional opinion against me. But in the early evening of the third day, about fifty-six hours after the birth of the child, there were two or three brief, sharp pains, and the placenta passed the vulva; and when I called, an hour or two later, I found it had been disposed of by the woman who was acting as volunteer nurse. This was a disappointment, as I would liked to have examined it, or sent it to some one who

was more competent ; but I was too greatly relieved by this happy termination of my anxiety, to feel much displeasure. Nor do I really think much was lost by the failure to make a rigid examination of these secundines. The microscope might have told of the nature of the fault ; but it is more than probable that the evidences of this had disappeared under the kindly influences of time and pulsatilla. If, owing to a previous endometritis, the ripening of the placenta was delayed, and if, under the influence of pulsatilla, this natural process was hastened to completion, then the extruded mass would hardly evidence an abnormality which had disappeared. The patient made an unusually quick and complete convalescence, and on the tenth day (from the beginning of confinement) was up, looking remarkably well. In fact, she about a month subsequently stated that she felt stronger and "more like herself" after this confinement than after either of the other four.

Another case of retained placenta was treated with gossypium. The patient, a spare, restless sort of a woman, was anæmic, and the blood was dark and watery. The child was born at 3 o'clock A.M., and the placenta came away at about 9 o'clock. The woman made a slower convalescence than in the previous case ; but this was due not to the retention of the placenta, but to impoverishment. The other four cases were quickly relieved, the longest being about three hours ; but as massage was used in each, and faradization of the breasts and abdomen in one, I cannot say how much credit should be given to the medicaments administered. A properly regulated faradic current applied to the breasts will do more to bring about a natural delivery of the secundines than the form of manipulation designated as *Credé*.

Finally, I am strongly of the opinion that adherent placenta need never occur, if proper treatment is given during pregnancy. We do not like to discredit ourselves, even to ourselves ; we like to think we are in the right, and the

fault was not with us; I know I do, and human nature is much of a muchness everywhere; but most obstetric bug-a-boos disappear before common-sense and experience. "Abnormal adhesions and hour-glass contractions are more frequently encountered in the experience of the young practitioner, and they diminish in frequency in direct ratio to increasing years."<sup>19</sup>

More serious, to my mind, are those cases in which, after an exhausting labor, the lower segment of the placenta detaches while the upper remains firm. The wearied womb refuses to be aroused to action, the flow of bright-red blood is continuous, and the necessity of prompt action is apparent to the least experienced eye. These cases have been "few and far between" in my practice, but I have had some anxious minutes over them. If after the first gush which follows the feet of the child into the world, I notice a little rill of blood trickling out from the lower segment of the vulva, I at once administer a dose of belladonna or ipecacuanha, the prescription depending on the well-known characteristics of each; I direct the nurse, or any one who may be at hand, to chafe the breasts while I massage the uterus. It would be convenient to have a good faradic battery at hand; but I never had except once, by accident. I have had cases where the loss has been considerable before it was finally checked. In two such cases I have given half-drachm doses of ergot (Parke, Davis & Co's normal liquid), and in several others Hayden's Styptic. The latter is composed of blended tinctures of cinnamon, fire-weed, and ergot, made with old French brandy. It improves with age, and it is best, therefore, to buy it by the pound, and leaving it sealed, set it where a strong sunlight can play on it. In a year or two it will be ripened, so that a small dose acts more efficiently than a large one of the freshly prepared. Dr. Hayden often keeps it six or eight years; I have some that was in the

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<sup>19</sup> Braun's *Lectures*. Berlin, 1869.

cask eight years, and which is now fast approaching its majority. This preparation of Hayden's is a more desirable styptic than pure ergot, as the after-pains are not increased by it, while after using *tinctura ergotæ* the after-pains are apt to be severe and long lasting.

Occasionally even in desperate cases the homœopathic remedy is so clearly outlined that even a mongrel homœopathist need not err. Thus *trillium*, *platina*, *sabina*, *phosphorus*, *ferrum*, *cinchona*, have been given with evident benefit; but usually the choice is difficult, and a mistake fatal.

Quickly cutting the cord and injecting cold water into the placental end of the umbilical vein will distend and harden that viscus, and induce contraction of the uterine parieties. This works nicely sometimes, but I can hardly speak of it as a *modus par excellence*; if it fails the patient will almost certainly have a hard chill.

Hegar,<sup>20</sup> of Berlin, called attention, nearly thirty years ago, to the fact that nature had a way of managing cases of adherent placenta which trenches upon the marvelous: that the entire placenta may be retained, may be absorbed, and no evil consequences arise. There are, at least, six such cases on record; Nægele reports two, Villeneuve, Porcher, Thrush, and Reamy, each one. As a matter of general interest I reproduce these cases in brief synopsis. The first four are from Hegar, the fifth from a paper by Dr. Thrush,<sup>21</sup> read before the Cincinnati Obstetrical Society, and the last from a verbal report of the case to the same society.<sup>22</sup>

CASE I. (Nægele's).—Patient a primipara; labor at about seven months gestation; the long, thin cord is torn out from its insertion in the placenta; midwife watches eight

<sup>20</sup> ALFRED HEGAR, M.D., *Pathologie and Therapie der Placentarretention*. Berlin: 1862.

<sup>21</sup> "Retention of the Placenta in Labor at Term," by J. F. Thrush, M.D. *The American Journal of Obstetrics*. Vol. x. page 389.

<sup>22</sup> *The American Journal of Obstetrics*, 1887, page 507.

days and nights at bedside of patient. For four days moderate lochial discharge, no foetus; twenty-four hours after labor slight febrile movement; no pain in abdomen; no milk. Eleven weeks thereafter patient menstruates again; subsequently conceives a second time, and after the lapse of fifteen months gives birth to a mature child, the entire labor being normal. Nothing was ever seen of the placenta of the first pregnancy.

CASE II. (2d of Naegele).—Multipara; labor at term normal to close of second stage, then hour-glass contraction; retention of the placenta; hæmorrhage. Thirty hours after labor; fetid discharge; removal by hand of about half of placenta; no lochia subsequently. Thirteen weeks later menses return; patient entirely recovered; remaining half of placenta never discharged. Two years subsequently renewed pregnancy; labor this time normal throughout.

CASE III. (Villeneuve's).—Patient a multipara; aborted at six months, giving birth to triplets; placenta of last two foetuses come away spontaneously, but that of the first is retained. On intra-uterine exploration placenta is detected in right upper and anterior region of the uterine cavity; cord torn out from its placental attachment. The lochial discharge is less than normal; patient is convalescent by the eleventh day after labor, and leaves hospital. Twenty days later has an attack of hæmorrhage, lasting almost uninterruptedly for eight days, nothing but blood passing away during the time. No discharge of placenta.

CASE IV. (F. Y. Porcher's, of Charleston).—Patient a multipara; third pregnancy; labor at term; child born in breech presentation. Immediately hour-glass contraction; placenta retained; hand passed into uterus without difficulty; afterbirth everywhere adherent. Ergot given in full doses; three days thereafter cord and a portion of membranes pass in a state of decomposition; copious foetid discharge; at three weeks after labor patient convalescent; a month later is seized with pain and a sense of weight in the pelvic region; uterus found low down, placenta felt through open

os, still adherent ; a week subsequently another paroxysm of pain, os this time closed. A year later patient entirely well. No placenta ever discharged.

CASE V. (THRUSH'S).—Nov. 25, 1875, about 7 P.M., called to Mrs. R., age thirty-three, said to be in labor—first child. Arrived; heard that “the waters had broke” four hours previous; large amount escaped; for severals days past had pain; small of back—lower abdomen. Much annoyed by constant uneasiness, amounting often to positive pain, referable upper and right side of abdomen; large projecting tumor; noticed many weeks. Patient believed labor “overdue.” Menstruated last, first week of January, forty-sixth week. Bloody discharge in February, unlike usual flow, she felt confident was not monthly sickness.

Exploration showed cervix obliterated,—os dilated for passage of two fingers. Extremity of fœtus forming tumor spoken of by patient. Remained at house during night. No material progress on 26th. “Lifeless body” extracted. Child, female, weighed 12½ pounds. No hæmorrhage. Looked for placenta. Taking cord as guide, found it high up in right side of uterine cavity, immovably fixed not detachable. No pain. Traction on the cord led to rupture of cord,—gave way at point of insertion. Gave fluid extract of ergot. Fifteen months after, nothing has shown what became of placenta. Patient now apparently pregnant.

CASE VI. (REAMY'S).—Had but one case in which absorption took place—a woman in sixth month of utero-gestation. Placenta not delivered—no offensive discharge. Three years after, again pregnant. No attempt at delivery of placenta, no hæmorrhage, no ill effects observable. Where absorption occurs patient rarely dies. Changes in uterine tissue help to prevent decomposition. Activity of uterine circulation helps to prevent decay. With morbid adhesions, very often friable condition of womb at placental site; hence womb liable to rupture or break at this point, especial care to be observed.

*(To be continued.)*



DYSMENORRHEA WITH HYSTERIA, TREATED  
BY XANTHOXYLUM.

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BYD. N. RAY, M.D.,  
CALCUTTA, INDIA.

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Miss S., aged sixteen, thin, fair complexion, nervous temperament, has been suffering from pains during her menses ever since they appeared at her twelfth year. For the last two years she had hysterical fits during her menses as well as at other times. They came at irregular intervals, sometimes at the interval of a fortnight. These fits were very severe and lasted sometimes for two or three days together. During the fits she was very violent; she would pull her hair, beat her chest, throw her hands and feet; and one most peculiar symptom I noticed in her, was that she used to bend like an arch on the bed, resting on her heels and head, and at the same time lifting her head every little while, used to throw it back forcibly on the bed. This she would continue for some time until exhausted, when she would lie quiet for a time and then repeat the same. She never used to eat anything during a fit, even if it had lasted for three days, but at a long interval when the jaws were not locked she would drink a large quantity of water, semi-conscious, and become insensible almost immediately. Her general health was not poor; her sleep was restless and full of frightful dreams. She was so full of fear that she would not go in a dark room alone at night. Her appetite was fair, but her bowels were very costive; they were sometimes moved once in a week. There was always a sort of heaviness on her forehead and temples, sometimes severe headache. There was a dull pain in the left ovarian region, which increased on pressure, but during her menses this pain used to be very severe and extended all over the

abdomen. The menses were of short duration—two or three days at most; the discharge was very scanty and of dark color. During the interval she had a yellow, thick leucorrhœal discharge, which used to disappear a few days before the appearance of the menses.

She was drugged by allopaths for two years without any benefit. She was also treated by native quacks with Indian drugs. This latter did her some good at first, but had not had any permanent effect. I treated successfully a case of hysteria among her relations, and this led her mother to try homœopathy in her case.

She was brought to my office first at noon on April 20, 1888. On her first visit she was very shy, and her friend mostly answered for her. I examined her carefully and pressed gently the painful part on the left side of the abdomen, which, as I have stated above, was tender and painful and the pain increased on pressure. On that occasion I prescribed lycopodium 3, four powders in a day, and she was told to call again after three days. It was to my surprise that a messenger came next day to inform me that my patient had a severe attack of fits, on her going home from my office, which had been continuing ever since. I went to see her at her home, and found the character of the fit similar to what I have stated above. I tried various mechanical means to cut short the attack, but did not succeed. One good thing came of this, that the locked jaws gave way by repeated attempts to open them by closely pressing the nostrils with fingers. I gave her a dose of Ignatia ama 3, and she became quiet in almost fifteen minutes after the dose. I left a few more doses to be repeated at a short interval if she should become violent, but the report in the evening was that she kept quiet all through the day, and in the evening she got up with a groan as if after a profound sleep. As soon as she became sensible she wanted to drink a large quantity of water and passed a profuse quantity of clear urine. She felt much exhausted after

the fit, and as was usual with her, this exhaustion continued for two or three days. From the next day, that is, from the 22d of April, she began to take the medicine prescribed for her. After continuing the medicine for three days she was brought to my office again. She was very much the same as before, but passed stool twice within six days. This the party thought was an improvement. April 25, I continued the same prescription, to be continued for another four days. April 29, the report was that she passed stool every second day, and she felt a little better on the whole; but her heaviness of the head, pain on the left ovarian region, and the dreamy sleep continued the same. April 29, I prescribed Ignatia 3, thrice daily. May 3, her sleep was much better, and the heaviness of the head much less. The same medicine was continued for a week more. May 10, she passed stool daily, sleep was good, the heaviness of the head almost disappeared, but the pain in the left ovarian region was unabated, and the leucorrhœal discharge nearly stopped, as her monthly time was near. I gave her Pulsatilla 3 two doses daily, till the appearance of the menses. On the 13th of May, they appeared, three days earlier; as a rule on previous occasions they used to be four or five days later. During this period she had her usual severe pain and very scanty discharge; had not had hysterical fit during the time, but the fit came two days afterward and was not so violent. The severe pain lasted over three days; sometimes it was so severe that she was obliged to scream. I tried Atropia, Apis, Lachesis, Pulsatilla, Caulophyllum, etc., without much good. On the 13th of June she was again at my office, and I pressed the left ovarian region, the pain there continued the same, and to my surprise she had a fit there and then. This continued till evening, when she was carried home. The attack lasted the whole night till next day noon.

I made up my mind to try *Xanthoxylum*  $\phi$  during her next courses. This idea struck me on the supposition that the

pain in the left ovarian region was of *neuralgic character*. So I advised the party to inform me just on the appearance of the next menses, and this they did on the 18th of July. I prescribed *Xanthonylum*  $\varphi$ , gtt. x., aqua dist.  $\mathfrak{z}$  ii, to be given one dessertspoonful every half-hour if the pain continued unaltered, and at a longer interval if it was less. In the evening, information was brought to me that after the second dose there was almost no pain, but one dose more was repeated. The discharge became very profuse, owing to which the patient was feeling exhausted. The character of the discharge was at first dark and afterward bright red color. I asked the party to discontinue the medicine, and to inform me about the state of her health next day. July 29, the discharge was a little less, but quite profuse, yet there was no pain. This time the menses continued for five days, and there was no fit during nor after the courses. The patient was much pleased with the treatment, but to my mind it was a question whether this would have a permanent effect. I discontinued all medicine for some time, and a week previous to the next courses I began to give one drop of the same medicine morning and evening. She had her menses on the 15th of August. This time the pain was very much less and the discharge quite free, so I had no occasion to give her any medicine during the menses. This time also she had not any hysterical attack; this was the second occasion she was free from any such fits. The same plan of treatment was continued again. She was again better. Now, on examination I noticed there was no pain on the left ovarian region on pressure. She is all right ever since.

From this case we see that the seat of mischief was in the left ovary; the frequent attacks of hysterical fits, neuralgic dysmenorrhœa with scanty flow, and other concomitant symptoms were all due to the mischief in the left ovary. It seems to me it is a capital remedy for ovarian neuralgia, though in practice it is less frequently thought of.

THOUGHTS ON GRADUAL UTERINE  
DILATATION.

BY

A. LEIGHT MONROE, M.D.,  
LOUISVILLE, KY.

Gynæcologists are becoming more alive every day to the fact that few diseased uteri can be successfully treated without thorough dilatation as an initial procedure. Differences upon this point arise only as to the manner in which it is to be accomplished, and its importance as a diagnostic and curative procedure. As to its use in sterility and obstructive dysmenorrhœa, and their reflex symptoms, there is no room for controversy, nor is there as to its importance in the field of diagnosis. I wish in this article to call special attention to the advantages of gradual and systematic dilatation in endometritis, its results and accompaniments, and the myriad reflexes arising from these conditions. This subject is only an incidental one to orificial philosophy as promulgated and constantly amplified by Prof. Pratt of Chicago, but for my best ideas on the subject and the best instruments for the work I am indebted to him. These instruments are Pratt's graduated steel uterine sounds, the counterpart in every respect, including number and size, of the metallic urethral sounds except that their curves correspond to the curve of the uterine canal instead of that of the urethra. The difference in diameter from one number to the next is so slight as to be hardly perceptible to the eye, and by beginning with the largest that will enter a given uterus with perfect ease,—generally a 5½, 7, or 8½,—one can introduce several at each sitting, beginning each time with the same size and increasing the maximum every one, two, or three sittings. After from four or fifteen such sittings, thorough dilatation (determined by

the sound meeting with equal resistance from the external os to fundus) is accomplished. The maximum sound is passed several times at intervals of six or seven days without inconvenience to the patient, and that part of the work is complete. My rule is to make my sounds my applicators, and use no cotton or lint to the endometrium. The clean sound is perfectly antiseptic, and each one is first dipped to a depth of three inches into a salve composed as follows: Vaseline, 80 per cent.; calendula, 15 per cent.; acid carbolic, 5 per cent. Upon each occasion after completing dilatation, the sound next to the largest used at that time is dipped into boroglyceride which adheres thickly to the instrument. This is then introduced into the uterus, held there several minutes, and then withdrawn. The patient is kept in the recumbent position while my instruments are being cleaned, after which she is allowed to get up. This treatment is mild, gentle, and soothing, can be given entirely at the office, and interferes in no way with the patient's regular avocations. After this treatment the endometrium is thoroughly antiseptic, with a free outlet for the drainage of all secretions from the cavities of the womb, ovaries, and fallopean tubes.

No threads of cotton wool or other organic matter are left in utero to decompose and set up a discharge. The vitality of any existing granulations is weakened by the pressure, and they are gradually absorbed or discharged. The nerves of the endometrium are stretched each time, its capillaries emptied and refilled with fresh arterial blood, and muscular spasm at the internal os gradually overcome. The rapidity with which reflexes often disappear during this treatment is most gratifying. When flexion exists it is more easily reduced by each successive treatment, and as the uterine circulation is improved and its muscular tissues strengthened the canal is reclaimed. There is little danger in the procedure to the prudent operator, as by avoiding undue force or the giving of pain one cannot produce suffi-

cient irritation or injury to set up inflammation. If force is to be used and the operation completed at one sitting, the only safe plan is to administer an anæsthetic, and procure then and there, by fixing the organ with a tenaculum, the fullest and most complete dilatation the canal is capable of without injury to its tissues, thus almost entirely avoiding the dangers of cellulitis or peritonitis. This I do where conditions either in the rectum or womb require more heroic measures. I am aware that most of what I have said will not be new to the readers of this journal, only claiming as I do some originality as to some of the practical details of the procedure and the scope of its applicability. Medicines and general measures are of course essential, the dilatation only places the patient in a position where recovery is possible. Such patients as require it—that is, patients with dysmenorrhœa, subinvolution, flexions, malpositions, endometritis, etc., generally require either Sepia, Nat. mur., *Lilium tig.*, Pulsatilla, Aurum, Jod., or Cimicifuga. *Lil. tig.*, is a grand remedy where the characteristic lancinating pains are present. They are often benefited also by Schüssler's tissue remedies, either Kali phos.—the nerve food,—or Calc. phos. and Ferrum phos.—the blood foods. It is often a good plan to keep them constantly on one of the tissue remedies, and to use those first mentioned as intercurrents to meet the reflex symptoms that appear from time to time.

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## LACERATION OF THE CERVIX UTERI.

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BY THE LATE

F. S. FULTON, M.D.

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(Continued from page 61.)

*Instruments and Room.*—The room in which the operation is done should be scrupulously neat and clean, and

should every little while be thoroughly disinfected by the use of carbolic acid, sulphur, thymol, listerine, or some of the many disinfectants. It is not necessary for the operation to adopt all the antiseptic precautions which are essential

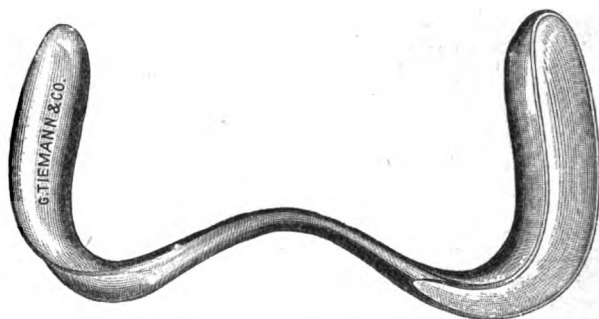


Fig. 8.—Bozeman's Duck Bill Speculum.

in an abdominal section. The various modifications of Sims's speculum offer a choice of shape and size. Some form of Sims's will, however, be required. The requirements of this speculum are that it shall be broad and shallow, not

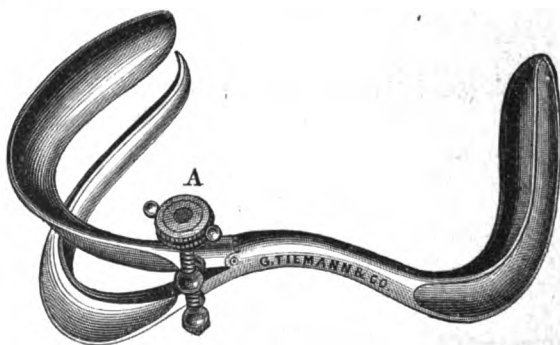


Fig. 9.—Dawson's Sims's Speculum.

exceeding 3 or  $3\frac{1}{2}$  inches in length. The most of those offered for sale are either too long or the blade is too hollow, and so occupies too much space in the vagina.

Dr. McDonald's modification of Sims's is one of the best.



Bozeman's as figured is good, but does not possess all the advantages spoken of above.



Fig. 10.—Emmet's Needle Forceps.

Dr. Dawson has modified Sims's by placing the blades on hinges for ease in transportation.

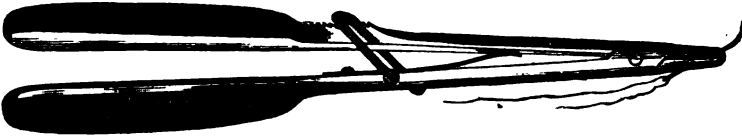


Fig. 11.—Russian Needle-holder.

Various needle-holders are used, such as Emmet's, Russian, Sims's, Skene's.

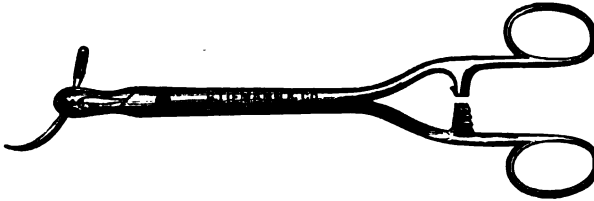


Fig. 12.—Sims's Needle-holder.

A modification of Sims's has been made by putting a catch on the handle, which greatly improves it. Skene has



Fig. 13.—Skene's Needle-holder.

devised a new holder for which he claims the special advantage of being able to better grasp and draw the needle through the cervical tissue.

For all purposes our preference is for the Russian forceps, as they grasp the needle firmly and are simple in construction.

For the operation three pairs of scissors are necessary,

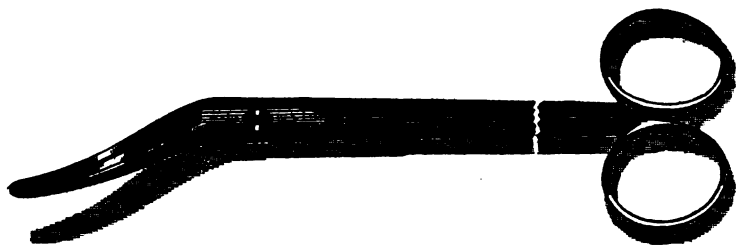


Fig. 14.—Emmet's Curved Scissors.

unless some of the more modern revolving scissors are used. Those needed are Emmet's scissors, straight, curved to the right, curved to the left, and curved on the flat as figured



Fig. 15.—Sims's Curved Scissors.

below. They should have strong, rather heavy blades, not the fine, delicate ones as are sold to the inexperienced. The

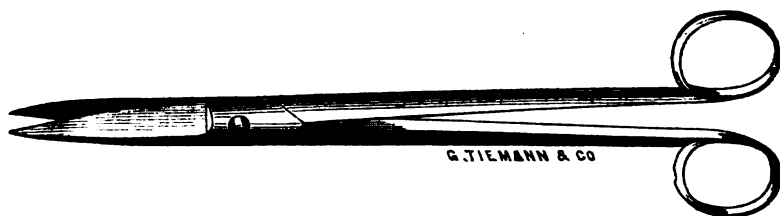


Fig. 16.—Sims's Straight Scissors.

tough cervical tissue, and particularly the cicatricial plug, will turn the blades if they are not pretty heavy.

There are scissors set in handles, as these devised by Mr. Stohlman, in which the blades can be made to occupy any

angle by means of a steel rod. They have been used with success in deep cavities where the application of others would have been impossible. The blades are firm and strong, and do good service.

If knives are to be used, and many operators are very

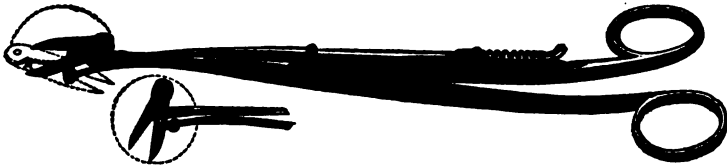


Fig. 17.

partial to them on the ground that the deeper angles can be more easily reached and tissue can be divided more accurately, three attached to long handles will be neces-

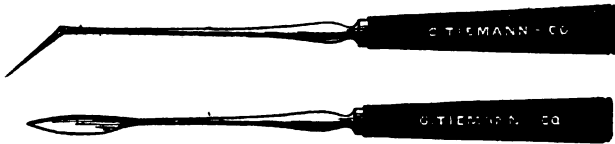


Fig. 18.—Bozeman's Scalpels.

sary, one straight, and two curved at the junction of the blade and shaft, and with the edge placed so as to allow of cutting either to the right or left. Dr. Helmuth clings to

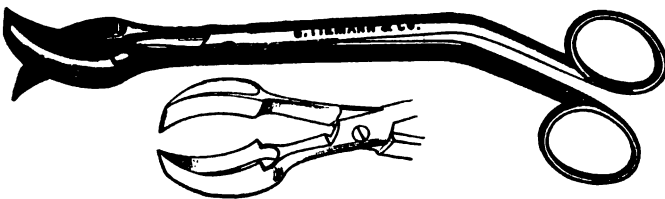


Fig. 19.—Skene's Hawk Bill Scissors.

the use of the knife with great fondness, claiming much greater rapidity and nicety of operation.

A double scissors has been recently devised by Dr. Skene

for the purpose of removing by one stroke and with greater certainty the tissue in the angle of the laceration.



Fig. 20.—Emmet's Tenacula.

Two small Emmet's tenacula will be needed to raise the tissue as it is dissected away.



Fig. 21.—Skene's Double Tenaculum.

A double tenaculum is often found exceedingly serviceable for drawing down the cervix toward the vulval orifice. Fig. 21 is one devised by Dr. Skene for that purpose.

*(To be continued.)*

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## A PATHOLOGICAL PUZZLE.

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BY

E. ELMER KEELER, M.D.,  
SYRACUSE, N. Y.

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Truth and falsity often join hands; in the legal profession this axiom we willingly believe, in theology we are compelled to admit its truth, and in medicine we find there is certainly no exception.

In law, facts of evidence may prove the guilt of a prisoner or the same evidence be construed to prove his innocence.

In theology, the fact of one hundred and a half present religious beliefs prove that error and truth must exist.

And in medicine the conscientious physician is ever diligently laboring that his diagnosis, prognosis, and treatment be verified and correct, rather than inaccurate and false.

In the following case time has unlocked some of the secrets, but may yet hold others under his key.

A patient, Mrs. S., aged thirty, has been married nine years. During this time and before marriage her health has been such as to enable her to engage in active daily work. She came under my care two years ago while attending her husband ill with typhoid fever, at which time she mentioned her inability to keep food on her stomach as the principal cause of complaint. In the overshadowing importance of her husband's case I thought very little of her ailments, gave her *Ipec.*, and advised care in eating and more sleep. But her case was destined to receive more attention than her husband's, for while he was speedily convalescent she was not cured by either *Ipec.* nor sleep, as will be seen.

In a few days she approached me again with the remark that her menses were suppressed, and the nausea, which was worse mornings, was no better. I then nodded my head wisely, gave her some *Puls.*, and said, "*Perhaps (?)* you have taken cold."

After this her husband's recovery made me know less of the progress of what appeared to be an ordinary pregnancy, until a few weeks after, when the lady presented herself at my office one morning so emaciated that she looked, as she said, as though she "hadn't had a square meal in a month." Together with the nausea she had needle-like pains in the *mammæ* and abdomen. These symptoms together with head and back ache, restlessness by day, and insomnia, made up the history of the next two months. In the mean time her abdomen had enlarged so she could wear none of her dresses, and the *mammæ* had become swollen and sensitive. But now a new symptom made its appearance; for

in from three to four weeks there would be a slight hæmorrhage from the vulvar orifice, lasting only a few hours. At this stage the patient frequently stated that she hoped she was pregnant, but feared it was too joyous news to be believed, as she had been told by a lady physician that such could never be the case.

I then suggested an examination, but this was refused, and another month passed. At the end of that she stated that frequently she experienced peculiar sensations in her then considerably enlarged abdomen, and said there was milk in her breasts. She then consented to a digital examination, which revealed—what? A contracted vagina, an infantile uterus, a conical cervix, and a pin-hole os.

This was the fifth month of *our* pregnancy.

I of course now placed very little faith in the symptoms which usually point the way so truthfully to pregnancy, and rather doubted the fact of the breasts having secreted any fluid, but upon examining,—lo, and behold! there was the milk or a very fair city substitute for it. I now became thoroughly interested, and working upon the two symptoms which I had found to be true, viz,—swollen *mammæ* and enlarged abdomen,—I endeavored to find what condition could exist to cause these two symptoms. To account for the abdominal enlargement I could not suggest excessive adipose tissue, for the patient was slight, and had there been tubal pregnancy it would probably before this period have ruptured the tube walls, and caused its usual result—death.

This assumption, as well as that of any uterine tumor, were not allowable now that I had made an examination, as the abdomen presented an even, smooth feel unbroken by the presence of any growth natural or unnatural.

But there were still these unexplained symptoms,—*mammæ* swollen, painful, and filled with a milky fluid, abdomen enlarged and menses suppressed. What was the cause? I do not know. I'll only tell what I *do* know. I commenced with Bovinine in small doses, peptonized milk,

and raw beef, advised rest, as she had all this time been at work daily in the shop, and gave such remedies as Apis., Puls., and Gels., with the result that the monthly discharge she had had for some time gradually increased until it was normal, the morning sickness ceased entirely, and she resumed her usual clothing.

She gained rapidly in weight, and since then has had no similar trouble excepting dysmenorrhœa, caused undoubtedly by the conditions of the os uteri.

But one peculiar symptom is still present in this peculiar case, and that is to this day every time her menses appear so does the milk in her breasts.

Why is it?

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## THE INFLUENCE OF HEREDITY IN THE TRANSMISSION OF DISEASE.

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BY

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An article written by Prof. J. W. Dowling, entitled, "Should Women with Heart Disease Marry?" and published in the JOURNAL OF OBSTETRICS, recalls experiences of my own in practice, and the conclusions that I had arrived at, in my humble judgment, from those cases.

It is hardly necessary, in an article of this character, to enter into an elaborate dissertation to prove the transmission of peculiar features, deformities, and temperaments, generation after generation, as this ground has been thoroughly covered by such writers as De Candole, Pritchard, Darwin, and Couch, yet it would be well perhaps to emphasize my own conclusions on these points, by stating in a general way some of the transmissible diseases.

Among these we may name goitre, leprosy, gout, scrofula, tuberculosis, cancer, rheumatism, cutaneous affections, asthma, insanity, chorea, and hysteria. In a less marked degree, we have lithiasis, diabetes, Bright's disease, and organic diseases of the heart. I grant that the improved hygiene of the present day enables the intelligent and conscientious physician to ward off many of these dreaded diseases, yet I claim it is his sacred duty in every way possible, by advice and warning, to prevent the marriage of persons that have marked and well-defined dyscrasias.

It may be a doubtful privilege for the whisky dealer to sell one more dram to the already excited and hilarious drinker, even if that is the one dram that completes a condition that results in a crime committed, but life and health are too precious, and the struggle for existence too great, for the intelligent physician in a happy-go-lucky sort of way to pass over, without using his strongest arguments and entering his most solemn protest against, marriages between parties whom he *knows* cannot propagate healthy children.

For instance, a young man contracts a gonorrhœa, complicated with a Hunterian chancre. After a year of apparent health, he courts, and asks her hand in marriage. The father of the young lady, having heard that the young man has been a little fast, consults me, and, from the advice given him, refuses the *honor*. To-day this young man is a confirmed cripple, unable to care for himself, certainly not capable of fathering healthy progeny. The young lady has since married a healthy young man, and is the mother of a fine healthy boy, with perfectly happy domestic life in the future. Again another young man marries a young lady with marked scrofulosis and a mitral lesion, both conditions inherited. She dies during her last accouchement, leaving, as a legacy to her husband, three scrofulous children.

A young man with fine physique, warm-hearted and passionately fond of children, marries a miserably dwarfed,



bandy-legged, narrow-pelvised girl, probably charmed by her pretty face and rather fascinating manner, and, I presume, a kind of manly sympathy for her in her infirmities and deformities. The result has been, that I have been called in five times to induce premature labors, to save the mother's life at the expense of the child's. During all these years the father has to see his own flesh and blood destroyed, to save the life of one whom the law should decree was not fit to occupy so sacred and important a position.

I could give case after case, to prove the wrong done to posterity by the marriage of diseased and crippled persons, as every physician of experience can, and I believe, if the American race is to be improved, or kept up to its present standard even, it can only be accomplished by legislation that will prevent the marriage of all deformed persons, as well as all persons of *marked* organic transmissible disease. To the sentimentalist, this may seem harsh and heartless ground to take, yet when we realize the care taken, and the expense incurred by stock-breeders to insure perfection, and then realize how perfectly reckless and thoughtless we are when it comes to the propagation of the race which is supposed to be created in the image of God, why should not wise laws be enacted to protect man, as well as beast?

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### ACUTE GONORRHOEA.\*

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BY

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BOSTON, MASS.

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Some three months ago a gentleman and his wife called at my office,—the man asking to speak first with me privately. He said his wife was suffering with some

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\* Read before the Boston Gynæcological Club.

urinary trouble and a profuse discharge, which made her very sore, and he was feeling some trouble himself, whether from the effect of her leucorrhœa or not he did not know. He did not think her trouble could have been taken from him, for he had consulted five or six physicians recently in different cities and they had told him there was no trouble of any consequence; but still he had all along a little mucous discharge, though not yellow or much in quantity. It was hardly necessary to seek for further evidence that he had in his travels contracted gonorrhœa, and though he supposed himself perfectly disinfected he still had enough latent germs about him to infect his wife when he returned to her two weeks before.

Examination of the woman gave further evidence, the vulva being swollen and inflamed, painful to touch, and bathed in a profuse milky leucorrhœal discharge, which caused soreness of the skin wherever it had touched. The urethra was swollen and sore, and the cervix uteri showed a like inflammatory condition, while the canal was filled with the characteristic plug, so gluey and clinging that it was almost impossible to remove it. After thoroughly cleansing the parts with a bi-chloride solution, I applied a tampon of wool saturated with a glycerole of aqueous hamamelis, and gave her internally acon. and canth. Hot sitz-baths were ordered to follow the removal of the tampon at night. Later hydrastis and merc. biniod. were given, but with the next menstrual period a swelling of one of the vulvo-vaginal glands caused much pain, and resulted in an abscess, which I evacuated by an incision on the inner or mucous surface of the labia, and ordered a hot poultice for the night. A few hours later I was called, as she was having a hæmorrhage from the wound, a dozen or more napkins having been saturated. This was easily controlled by a little firm pressure, as it was only venous. The explanation of this hæmorrhage was found in the fact that she was a constitutional bleeder, having repeatedly

bled from the nose till almost completely exsanguinated, and a cut or prick of a finger would cause long-continued loss of blood. The inflammation of the urethra and external genitals having been entirely overcome, there remained only that in the cervix, and that I hope I have now so controlled as to prevent the extension of the disease to the endometrium and tubes; but I am not yet sure of it, and shall wait for the evidence furnished at the next monthly period. If that is normal, free from unusual pain, and not excessive in quantity, and I find afterward the cervical canal free from the gluey secretion, I shall feel that she is cured; but if the germs have reached the endometrium and tubes I do not believe anything less than extirpation can eradicate the disease.

Now, gentlemen, I report this case not because it is very remarkable, but in order to raise two or three questions for discussion.

First: Is it right, or are we justified, in keeping a patient in ignorance of her real condition, and shielding a husband who has violated all claim to her attachment and inflicted upon her what may be a life-long curse?

Second: What is to be said of physicians who make light of gonorrhœa in their male patients, and give them to understand that they are cured when the pain and profuse discharge have been controlled, even though they still have a gleet or colorless discharge?

Third: In view of the terrible consequences of gonorrhœal infection in women, ought we not to make an effort to secure some legal protection for women?—at least to require every man who would marry, to have a certificate of absolute freedom from any trace of venereal disease? For myself, I would have it made a criminal act for a man to contract gonorrhœa after he is married, and make the penalty fit the crime.

## THE RELATION OF HOMŒOPATHY TO GYNÆCOLOGY; OR, SECTARIANISM IN MEDICINE.\*

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BYMARY A. BRINKMAN, M.D.,  
NEW YORK.

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Much has been said and written on sectarianism in medicine. The expediency of open affiliation with homœopathic practitioners has lately been under discussion at two meetings of the Philadelphia County Medical Society. In our own state and county societies there is a strong undercurrent of feeling amongst many, that with the advance of science in all directions so-called sectarianism in medicine is undesirable. The feasibility of dropping the distinctive title of homœopathy has been mooted by some, and the advisability of merging ourselves into the mass of self-styled "regular" physicians. We are accused of professing homœopathy, but of "hourly violating its canons in practice." Thoughtful minds are questioning the relation of the law of "Similars" to the advance of therapeutics on other lines, and are vindicating their sincerity as professing homœopathic practitioners. It may be that some are drifting with the current of pure empiricism, but the scientific homœopathic physician is not willing to be proclaimed an "impostor," a "charlatan," a "man given over to errors which are fundamental and which have been systematized into a creed." One of our oldest exponents of homœopathy has been quoted in the public press as saying that there are no exclusively homœopathic physicians in New York City. We naturally ask, what is meant by being an exclusively homœopathic physician? No honest mind questions the

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\* Written for the Alumni Association of the New York Medical College and Hospital for Women, Dec. 18, 1889.

inestimable boon which Hahnemann conferred upon humanity by proclaiming the law of Similars at a time in the history of medicine when crude and unskillful procedures were the rule of medical practice. Instance the effect of minute doses of aconite to calm the violent perturbation of the vascular system in acute febrile conditions, in place of withdrawing large quantities of blood, of which there is no more in the veins than before the onset of the fever. He who carefully studies the history of medicine previous to Hahnemann's discoveries will see what an impetus he and his followers have given to medical research on broader and more rational lines of thought. "All homœopathic physicians are united in their belief that '*Similia similibus curantur*' is a law of cure, however they may differ as to the theoretical explanation of that law, or the extent to which it may be applied."

Hahnemann gave one drug at a time to the healthy and noted the effect. He applied the same drug to the sick who presented similar symptoms to those evolved by the action of the drug upon the healthy, and with curative results. Thus was promulgated the homœopathic law of cure. The comprehension or understanding of truth or fact by the mind as expressed by the word *science* is ever progressive, but Truth is eternal. Whether we conform to theories by which facts are deduced is of minor importance.

The expression of vital force is exhibited in the various activities of the living body. When its functions anatomically, physiologically, chemically, and spiritually act in harmony, a person is said to be in health. Any departure from harmony of action is disease. It is expressed in different ways according to the functions and tissues involved, the temperament and disposition of the person, and the cause of the disturbance. This expression of inharmony, or the symptoms subjective and objective, is the disease itself as far as we know it; although for convenience of

classification we use names which have relation to the organs more especially implicated in the morbid process.

There are many conditions under which persons suffer that strictly speaking are not diseases at all. Excesses of various kinds, as the over-indulgence in the use of tea, coffee, tobacco, and alcohol; over-eating, eating at improper times and of food prejudicial to the economy; the want of the necessities of life, habitations in unwholesome countries or dwellings, want of the proper amount of air and exercise, the exhaustion of the mind or body from over-work, uncongenial occupations or the want of occupation, the hourly contact of the spirit with those who fret the soul into unrest and disorder. These latter cases are common even in families united by the bond of love. The ignorance of mistaken kindness, the lack of knowledge of the temperament, the dominant will overpowering the other until illness results from the struggle of the weaker to maintain its spiritual equilibrium,—these cases are familiar to every observing physician.

There is the large class of purely surgical cases, the larger class of mechanical disturbances,—these and others are properly not subjects for the therapeutic art at all, in the sense of the application of drugs for their dynamic effects. These privations of health will disappear of themselves if the patient be placed under the right conditions. In many of these cases change of regimen will restore the patient to health. Change of diet, dress, climate, the proper use of the gymnasium or the bath, rest of mind and body, abstinence from hurtful excesses, healthful occupations, in short all the varied adjuvants of the healing art that science suggests, are daily called into use in these and similar cases by the homœopathic physician.

As a specialist in diseases of women we are led to consider in what sense a gynæcologist who strives to keep pace with the advance of medical science may be an avowed homœopathic physician and not be accused of

violating the "tenets" of homœopathy in daily practice. Among the multitudinous variety of new discoveries in medical science the theories that are advanced from time to time by earnest students, as well as by would-be discoverers who are ambitious of followers, in the midst of the avalanche of microbes and bacilli with which we are deluged, with proposed inoculation for preventing or mitigating the suffering of cholera, yellow fever, syphilis, small-pox, phthisis, and hydrophobia; and lastly the crowning discovery of the "elixir of life,"—in the midst of all the chaff with the wheat, it becomes us to keep diligently before our mind some guiding principle whose lines we may follow, or we shall be utterly wrecked. The gynæcologist must be a student of the whole field of therapeutics. It is not enough that he be able to recognize a dislocated uterus and to straightway prop it up mechanically, to curette the endometrium for protracted hæmorrhages, to attempt to straighten flexions by incision, or dilatation, to cut off relaxed and redundant tissues. The thoughtful gynæcologist recognizes the fact that the more closely he studies into the causes of so-called local diseases of the pelvic organs, the more he questions the dogma of local disease. In most of these nutritive disturbances he sees the expression of a general affection. Phthisis, diphtheria, typhoid, typhus, syphilis, gonorrhœa, etc., select certain tissues for local manifestation, but they are, or soon become, constitutional derangements. We know little or nothing of the causes that lead to fibroma and carcinoma. We have strong reasons for our belief that many of the intractable ills from which women suffer are due to the poison of gonorrhœa. Healthy women through marital relations become victims to this disease in its subtle forms, whose husbands honestly believe themselves cured at the time of marriage, because there is no local, visible sign of the infection. Here is a field for preventive medicine which comes largely under the sphere of ethics.

The gynæcologist is confronted at every turn with physical wrecks, many of which may be traced to ignorance, vice, or carelessness. Note the train of evils which often follow from a lacerated cervix uteri, or perineum. Many or most of these cases of permanent deformity are due to the carelessness of the attendant in the lying-in room. Judicious treatment during the period of gestation, care and skill in management of labor, is the plain duty of the obstetrician. Patient waiting upon nature, carefully guarding her efforts, assisting her when the welfare of the woman demands it, more careful use of the obstetrical forceps, more self-denial in the effort to gain facility in the use of instruments, will greatly lessen the percentage of these and other accidents. Many of them are unavoidable even in the hands of the most conscientious practitioner. When the obstetrician gains fame and reputation from the number of lying-in cases that pass the ordeal normally, there will be less said of the "trained" nurse, the vaginal and intra-uterine douche, powerfully poisonous disinfectants, and of the train of evils that follow so closely the "birth of the baby." What should be a normal physiological process has become the woman's terror, and expense, worry, and prolonged illness is, we fear, becoming more the rule than the exception. Many of the pelvic troubles from what women suffer are the result of chronic starvation in the midst of plenty. Neglect to take the proper amount of air and exercise, unsuitable food, insufficient amount of food, clothing unsuitable in quantity or quality, or in the manner of its distribution, all these causes combine to weaken the forces of resistance. Especially is this true of young girls growing into womanhood. Through ignorance they disregard the laws of health, and their natural guardians by culpable neglect do not see to it that these laws are obeyed. Their forced mental growth at the expense of physical, the predominance of the emotional nature, fostered and cultivated by our present civilization, excesses of many kinds, all these influences tend to bring



our young women early into the hands of the gynæcologist. Their manifold ailments have their predominant expression in the disturbance of the pelvic organs, while the whole system is more or less involved. Digestion, nutrition, assimilation suffer. Anæmia, chlorosis, uterine displacements, ovarian irritation, congestions, hysteria, hystero-epilepsy, leucorrhœa, menorrhagia, and a long train of symptoms follow. The terms neurasthenia, nervous exhaustion, fall glibly from the lips of our young women. What is the matter? What is the gynæcologist to do? Shall he resort to the latest medical 'fad,' and remove the ovaries? cut off elongated ligaments, stitch the retroverted uterus to the abdominal wall, etc.? Alas! in some cases even these bungling methods seem to be a last resort, too often ineffectual with all the suffering and danger they entail. Such procedure should be the rare exception and can seldom be justifiable. Mutilation is not cure.

The gynæcologist faces in daily practice many perplexing problems. How is he to solve them? He is expected to undo the results of indiscretion, carelessness, ignorance, and sometimes of crime. He must carefully trace out the causes of these disturbances of health, and minister to the disordered system according to its needs. How often he stands powerless in the midst of abuses that he cannot correct.

Dr. St. John Roosa, in a late paper, touches a vital point in preventive medicine. He writes: "If a committee were appointed to go up and down the land, visiting our colleges, public schools, academies, and seminaries for young women, and if this committee should be brave enough to tell the whole truth about insufficient drainage of grounds, imperfect ventilation and lighting of rooms, if they were to tell how many hours were devoted to study, sleep, and exercise respectively, what was the quality of food, how many recitations occurred when the stomach was empty, or containing only stimulating but slightly nutritious liquids, if they told how many young women were violating the ordinary physi-

ological precautions, we should have some more of the same kind of literature as that furnished by the Prison Association. . . ." If an investigation were ever made as to the quantity of air in the lecture-rooms of our medical colleges, where, among other things, lectures on hygiene are delivered, this commission would have a somewhat startling remark to make on that subject; and as for our churches, it has long been decided by our architects that a sufficient quantity of fresh air is not to be obtained in them.

The gynæcologist must endeavor to root out the enemy wherever it lurks. The whole field of therapeutic art is his. Mechanical symptoms are often best relieved by mechanical means. By the proper application of tampons he may support a dislocated uterus and the pelvic roof temporarily, and thus relieve relaxed and overloaded blood-vessels; leucorrhœa and menorrhagia may often be checked by this means alone. These symptoms are an effort of nature to relieve overtaxed tissues. Palliative means are legitimate as a temporary procedure, but the gynæcologist who ceases his efforts here will not cure his patient. When he uses harmless mechanical means for a temporary remedial effect let him clearly recognize it. In bringing the law of mechanics to his aid there is no law, written nor unwritten, whereby he may be accused of violating the "tenets" of homœopathy. If the digestion is so far impaired that ordinary food cannot be digested nor assimilated, he may direct the use of concentrated foods adapted to the case. If the science of chemistry be brought to bear upon a case with its aids to promote health, such procedures belong to his province as a helper and healer of the sick. To effect a *cure* he must not only combat causes in the realm of physics, chemistry, and hygiene, he must go further and apply the remedy adapted to the dynamic disturbance. The vital forces must be set in harmony before the patient will be cured. Here is where the law of "similars" works so effectively. He who neglects this field of the therapeutic

art will meet with signal failure. We are none the less believers in the law of *Similia similibus curantur* because we bring to our aid the sister sciences. Hygiene, mechanics, chemistry, physiological research, microscopic investigation, surgery with its brilliant achievements, should all be brought to the aid of the true physician. He should have a definite reason for what he does, and not blindly follow any method because some noted physiciau uses a certain formula or performs a certain surgical operation under given conditions.

The field of labor of the specialist is not narrowed but enlarged. If he drops into routine practice, he limits his usefulness. Perhaps in no other branch of medical practice is there such scope for thought, research, and general knowledge. Organs remote from the pelvis may be primarily at fault. The sphere of the emotions may not be overlooked. By a due regard to the mental symptoms the proper remedy may frequently be selected and recovery follow. Depressing emotions are known to cause and perpetuate disease. The pelvic organs of women are prone to suffer from this cause. Reflex disturbances may be centrifugal as well as centripetal.

Psychical medicine offers a broad field of research to the gynæcologist. The sexual life of the young does not receive its due share of attention from teachers and guardians. Before maturity is reached the vigorous stream of sexual activity is in many cases perverted and turned from its proper functions from lack of judicious knowledge on vital questions that concern the physical welfare. Much of the literature written with a view of meeting this want is mischievous, and fails to serve its purpose. Conjugal onanism,—yea! conjugal crimes are a dark blot upon our boasted enlightenment and civilization. Every phase of the various and varying manifestations of life confronts the gynæcologist.

A specialist must also be a close observer. By deep study

into cause and effect, by careful selection of the drug according to the homœopathic interpretation of the law of Hahnemann, he will be able to cure many cases, and will rarely feel called to resort to the minor or capital surgical procedures. All physicians know how often surgical operations upon the pelvic organs leave the patient worse than before they were attempted. We owe a large and ever-increasing debt to the brilliant achievements of surgery, and especially to abdominal surgery. Let us use our privileges as stewards who must give an account of our stewardship. On the other hand, it is not the part of wisdom to "burn the midnight oil" searching the materia medica for the "similia" of symptoms which are out of the domain of drug action altogether. Pruritis, a symptom so common to many disorders, will in diabetes demand for its relief change of regimen combined with drug action; if due to parasites, extermination is called for, and if to lack of cleanliness, no one will accuse us of violating the "tenets" of homœopathy if hydropathy is made to serve us.

When we select drugs for the sick for their dynamic and curative effects, we are guided by the law of *Similia similibus curantur*. We see no good reason for dropping the distinctive title of homœopathy, which stands for a distinct law of cure, and which has borne the test of time. Although the pioneers who first recognized and practiced this law of cure were compelled to form themselves into a separate organization, we who inherit the fruit of their labor should be slow to lower the standard they have so nobly borne to victory. As educated physicians we make use of all the means and appliances that science has brought to our aid. As homœopathic physicians we practice a law of cure whose beneficent influence has modified the thought and practice of the whole medical world.

219 West 23d Street, NEW YORK CITY.

## LABOR AND ITS TREATMENT.

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BY

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PORTLAND, ME.

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There seems to have been a sort of epidemic in the medical journals, of late, in regard to the care of mother and child during and after labor; and I am fully impressed with the idea that these jottings of experience or practice from those who have done the work is of much benefit to all physicians; and as in this world there are "many men of many minds," and especially is it found so in the practice of medicine—it seems well that we should all give our personal experience.

First, I would say to all, watch your patients during pregnancy when it is possible. Many little errors in gestation can be easily corrected by proper treatment, which if allowed to go on to the end of term many involve you in some inextricable difficulty. Many of these little errors, or deviations from health, are as a rule considered by the patient as a part of the condition that they are obliged to bear,—especially urinary troubles, which are only the forerunners of that dangerous trouble and to the physician a hydra-headed monster, puerperal eclampsia. Know your patient if possible. The experienced seaman, when he sees a peculiar cloud in an otherwise clear sky, prepares his ship for trouble and thus averts disaster, instead of consoling himself with the idea that his ship is strong and taut, and she can weather the gale. The principal topic on this subject seems to be the third stage of labor. In a quite large and successful obstetrical practice of fifteen years (I say successful, because in some two hundred and fifty cases in that time, I have not lost a child and but one mother), I have allowed "Dame Nature" to have her way, unless labor

was being too far prolonged ; then I would use the proper internal medication. Physicians are too apt to yield to the desires of the mothers, coupled with the tired condition of their own system, and hurry matters or use forceps, where no necessity demanded it, except to get through ; the result of which is ruptured perineums, etc.,—perhaps lacerated cervix with all its attendant evils. Should the pains begin to get weak and long intervals between, I have always found that 8 or 10 drops of fld. ext. ergot in a goblet two-thirds full of water, a teaspoonful once in fifteen or twenty minutes, would soon restore them. As the head reaches and commences to distend the perineum, I support it with the palm of my hand, and near the close of expulsion I do not allow the mother to aid herself by straining any more than possible. I think in this way I have saved many perineums.

As soon as the child is born, and fills its lungs, I wait for nothing, tie the cord, and cut it. As soon as I have turned the child over to the nurse, I grasp the womb in my hand externally and gently compress it. I then wind the cord around the fingers of my left hand, introducing two fingers of my right hand into the vagina until I feel the connection of the cord with the placenta ; then by gently but firmly drawing on the cord and at the same time pressing down and backward with the fingers of my right hand, the placenta is easily delivered. By this method I have never had a retained placenta, but have always found it in the vagina awaiting my action. The binder I prefer to use, as I think it supports the walls of the abdomen and prevents the relaxation of the uterus—thus preventing hæmorrhage. The cord I have dressed in absorbent cotton and laid on the left side, as it does not then crowd the liver. I have the child put to the breast once in two or three hours until I find whether the mother is going to have any milk or not, feeding the child, in the mean time, with an occasional teaspoonful of warm water sweetened with *sugar*. The mother's food during the same time to be simply gruel or a little

toast, and weak tea; after the milk is established, then she can eat any wholesome, nutritious food, and she must remain in bed nine days at least, no matter how well she feels.

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## ● EDITOR'S TABLE. ●

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Professor Ricord died of pneumonia at Paris on the 22d of October. Among all our French *confrères* there is not one whose name is more widely known, nor one whose death is more universally deplored, than that of Philippe Ricord. We, in America, have also some reason for pride in the brilliant career of our regretted associate, for he was born in Baltimore and began his first medical studies in the United States. To the scientific attainments of Ricord we owe the solution of many problems in syphilography. He also became one of the first to employ the vaginal speculum, *understandingly*, and leaves as a memoir of his early work in this direction, "De l'emploi du spéculum" (apropos of a bivalve speculum invented by himself), 1833, and "Blenorrhagie de la femme," 1834.

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In the December issue of the *Cronica Médico-quirurgica de la Habana* we find a long disquisition on the treatment of an ovarian cyst by injection of iodine and potassium iodide. In *résumé* the author claims that this treatment is applicable only to unilocular cysts of the ovary. At this day, and in the light modern surgery has thrown upon the treatment of pelvic tumors, we regret to see our Spanish *confrères* returning to so antiquated a treatment as injection of an ovarian cyst. The difficulties of diagnosis are so great before the abdomen is opened, and the dangers of an exploratory incision so slight, compared with those surrounding the man who blindly plunges a trocar into the ventral cavity, that we feel called upon to severely criticize any attempt to revive these old methods.

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Dr. S. A. Garcia publishes (*La Cronica Médica de Lima*,) the results of a year's service at the Maternity Hospital, of Lima,

Peru. Among 428 women delivered, only two deaths occurred ; of these 428 births, in 403 natural labor occurred, in 10 cases manual assistance was required, and in 15 cases the delivery was by instruments. In looking over the statistics we cannot but feel that the influence of race had much to do with the good results obtained, for, of the whole number of women delivered, only 34 were whites, 34 negroes, 143 mestizas, and 217 Indians. The large proportion in these statistics of those subject to out-door life and active exercise must have had an influence in giving so great a proportion of natural labors. We would have found great interest in noting the proportions in which the instrumental deliveries were distributed between the whites and the other races, but Dr. Garcia has failed to note them.

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Kaltenbach, of Germany, has performed total extirpation of the uterus fifty-seven times, fifty-three times for carcinomata, twice for sarcomata, and twice for prolapsus. He finds that this procedure is indicated in carcinoma in the uterus in every case in which the technique of the operation is of possible execution ; he even hopes to bring about a complete cure.

In principle, partial extirpation appears to be sufficient, but in practice it is rarely indicated. The tendency to return of a carcinoma after amputation of the cervix is too great a possibility to take any chances, when total extirpation has so good a record to present. In one case cited by Kaltenbach, we have one of the rare indications for partial extirpation. He made a partial extirpation in the case of a woman, in her seventh month of pregnancy, in whom he found a small carcinoma the size of a hazelnut on the anterior lip of the cervix. This he removed by excision, and the pregnancy followed a natural course. In a general way, Kaltenbach is of the opinion that in all cases, where a partial extirpation would necessitate going beyond the vaginal insertion, total extirpation is to be preferred. Of his fifty-seven total extirpations Kaltenbach has had only two deaths. In one of these death followed from uræmia induced by ligature of the left ureter, and perhaps also by wound of the bladder. In the two cases Kaltenbach was obliged to perform colpocleisis on account



of vesico-vaginal fistulæ. With regard to return of the disease, twenty-five of the carcinomata have not reappeared after one year. All the patients recovered promptly after the operation. The treatment in case of return was cauterization by the thermo-cautery and chloride of zinc. In one case, a carcinomatous fistula of the bladder was cured. In reviewing this work of Kaltenbach we find it the equal of a few prominent operators and much superior to the record of many others. It shows us the value of total extirpation of the uterus, when executed at an opportune moment, as being greatly superior in results to temporizing by resorting to partial extirpation.

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Dr. S. Kurse has presented to the Obstetrical Society of Chicago an interesting (to the old school) communication on the influence which the fluid extract of *cimicifuga racemosa* exercises over parturition. He prescribes five drops of the fluid extract in the syrup of sarsaparilla, to be taken each night, during the month preceding parturition. According to the author, this will diminish the duration of the first and second stage of labor nearly one-half. "It calms the reflex irritability, the nausea, the pruritis, and the insomnia of the last period of pregnancy; diminishes or even suppresses the irregular pains of the beginning of accouchement; facilitates labor, and diminishes the chances of laceration, by relaxing the muscular fibres of the uterus and vagina. Finally, the energy and the rhythm of the pains of the second stage will be augmented, and like ergot of rye it assures uterine contraction after delivery," so says this discoverer (?) of these wonderful properties of *Actæa racemosa*. Evidently, this larceny is so bold that we may safely leave Dr. Kurse to take his just dues from our readers, without further comment on our part.

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Gottschalk, of Germany (*Gazette de Gyn.*), is advising the treatment of pyosalpingitis by extensive dilatation of the uterus. This treatment, he says, is especially indicated in cases where the tube is distended by pus, and does not prevent incurvations or strangulated portions, giving distinct pockets filled with pus. In these last cases it is evident that extirpation of the tubes is the

only remedy that has a chance of success. But taking the first class of cases, to which the author directs his method of treatment, he commences by a very large dilatation of the uterine cavity. This, carefully conducted, opens the way for a natural flow of pus. Dilatation is made by iodoform gauze, or laminaria tents. Care is taken after each dressing to use intra-uterine injections. The intra-uterine tampons remain in place from one to three days. They imbibe the pus little by little, and thus drain the tubes. The intra-uterine tampon, while enlarging the uterine cavity, dilates the opening of the tube by the same mechanism. Gottschalk, however, does not give the reports of any cases he has treated by this manner, and we confess that we put little confidence in his theory. The drainage of a large amount of pus over a surface so rich in lymphatics as the endometrium appears to be a proceeding not less dangerous than laparotomy with extirpation of the fallopian tube.

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## ● GOLDEN GRAINS. ●

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—Besides the two classes of benignant non-recurring uterine polypi, commonly known as mucous and fibrous, there is a class of pathological formations giving the same symptoms, but of very different structure. They are the result of retained membranes or blood-clots, especially after abortions, may remain latent for a long time, and are exceedingly difficult of diagnosis, being very variable in consistence, situation, and other uterine conditions.

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—In uterine congestion, with uterine hæmorrhage, particularly when there is a flow of blood between the menstrual periods from any little over-exertion, *bovista* has been found very useful. The menstrual flow of *bovista* is characterized by *occurring only at night or early in the morning*.

\* \* \*

—In tamponing the vagina or the cervical canal for uterine hæmorrhage, it will be found preferable to lubricate each separate

pledget, as it is introduced, with vaseline. Thus treated, the rolls of lint or cotton slip into place easier, and the vaseline prevents the blood from soaking into the pledgets, and oozing as it would were they not greased.

\* \* \*

—In studying the action of oleander on the abdominal organs, we find emptiness and goneness in the pit of the stomach, even after eating, relieved by taking brandy. This symptom is an occasion for oleander in very weak women who have infants at the breast. Immediately after nursing, the patient is seized with tremor, and is so weak that she is scarcely able to walk across the room.

\* \* \*

—There is a point in the pathology of inflammation of the pelvic tissues which has not been very prominently brought forward. We refer to the danger to the kidneys and ureters, either from an extension of the inflammation or from the mechanical influence exercised by the pressure of pelvic exudates. Both of these conditions lead to slowly developing forms of nephritis, and endanger the ureters in a variety of ways not readily diagnosed and often impossible to detect. The compression exercised by exudates is more evident, either from masses in the vesico-uterine space upon the trigone and the extremities of the ureters, or from extravasations in the broad ligaments, which force the ureters against the brim of the pelvis at the junction of its pelvic and abdominal portion. The ureter is most exposed in its passage through the parametria, when slight indurations or small nodules may affect it, or, again, it may be compressed and distorted by cicatrization and contraction of tissue.

\* \* \*

—Besides the use of *opium* to relieve retention of urine after parturition, attention has also been called to its curative effect in children, when, from fright of the wet-nurse, the infant has retention of urine. As a remedy for affections in women resulting from *fright* opium has further seemed indicated in puerperal fever; where there is over-excitement of all the senses; even distant sounds annoy the patient; the discharge from the uterus is very foetid. The case approaches a condition of stupor.

—Miall says that when a mammary abscess is on the point of forming, he has frequently seen all the symptoms disappear in a few hours under the influence of fomentations with hot water and carbonate of ammonia. He uses an ounce of the carbonate in a pint of water, and, when solution is accomplished, the temperature of the fluid will be hardly too high for fomentation to be commenced with cloths dipped in the liquid. He applies them from half an hour to two hours, at the same time protecting the nipples. He has often had immediate relief, and seldom requires more than three applications.

\* \* \*

—Of the properties of the muscular fibres of the uterus, the most essential are *extensibility*, *retractility*, and *contractility*. *Retractility* is the antagonist of extensibility. It is an inherent property of the uterine fibre, surviving after death of the woman, and depends in part for its integrity upon the nutrition of the elements of the muscular fibre. This is an essential property because it permits the uterus to retract spontaneously upon itself, tending thus to empty its cavity. Retractility is generally better assured and more perfect among the primiparous than among the multiparous. It is less powerful in the inferior segment of the uterus and in the cervix, than in the main portion of the body of the uterus.

*Contractility* intervenes each time that the uterus contains a foreign body to expel ; it is generally painful. Retractility and contractility are distinct properties ; although they often act together and are often confounded, yet they are not the less independent of each other. And here is a practical point to remember, that is, the after-pains attending the *contractions* of the uterine muscular fibres are not always coincident with *retraction*.

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—In children affected by worm symptoms, *sabadilla* may be used, when there are nausea and vomiting associated with a peculiar colic as though the bowels were being whirled around like a wheel.

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—Dr. Spencer gives the following diagnostic signs for detecting placenta prævia by abdominal palpation : In head-presenta-

tion with placenta prævia the head cannot be felt where the placenta is situated; may be distinctly felt where the placenta is absent. The placenta, when in front, may itself be felt as an elastic sponge-like mass which keeps the fingers off the head. The edge may be made out, having the shape of a segment of a circle. Within the circle all is obscure to the touch; outside the circle the head or other part of the child is plainly felt.

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—J. Price, in the *Annals of Gyn.*, summarizes the following as advantages possessed by the Porro operation over Cæsarian section. The danger from the succulent uterus with its incision is removed, hæmorrhage is absent, the operation is more rapid, the technique is more simple. The uterine suture is unreliable owing to the instability of the uterine tissue during involution. Possible leakage and peritonitis are almost inevitable dangers in Cæsarian section. On the other hand the écraseur adopts itself to the shrinking stump, and, more important still, the stump is extra-peritoneal. The Porro operation should give better results than ordinary hysterectomy for the following reasons: 1. Absence of adhesions. 2. No implication of any important viscus, and therefore less hæmorrhage. 3. Less shock.

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—ERYTHROXYLON COCA IN VOMITING OF PREGNANCY.—Marc Laffont, M.D., of Paris, has recently been using a preparation of coca for vomiting of pregnancy. It is found available in severe cases where other remedies have failed, and where mechanical interference is apparently the only resource.

During the last few years the therapeutic use of coca has been greatly extended. Although coca has, from its earliest introduction as a pharmaceutical product into France, enjoyed the highest professional recognition, this South American plant can hardly be said to have entered into current therapeutics. It is only since the discovery of the scientific application of the alkaloid of *Erythroxylon coca*, and since the important essays on the drug and the experiments made with it, that physicians generally have studied and recognized its therapeutic value.

In consequence of the tests made with cocaine, which, from a

physiological point, have established the dose and the limit of its toxic effect, and, from a medical view, have brought to light cases of abuse which have resulted in more or less serious accidents, many have been led to regard the plant coca itself as a dangerous drug. And so it is unless a pure and correctly prepared preparation is used.

The proof of the therapeutic value of the coca leaf is clearly shown by the many excellent results obtained in practice with such reliable preparations of the drug as have been furnished by Mariani, the worthy pharmacist of Paris. Its action naturally varies unless the preparation be uniform, and we know of but one that is reliable, *i.e.*, Vin Mariani. The virtues of the plant vary according to where and how it is gathered, the place of its cultivation, its quality, and the constitution and nature of the preparation, and nothing can replace the active principles and the essential oils of the leaf of *Erythroxylon coca*, as has been proved from the time of the earliest discovery and use of this plant. This is particularly noticeable when prescribed for vomiting of pregnancy, and doubtless it is not different in other cases where the remedy is indicated.

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—Dr. Goldsbrough, in the *British Homœopathic Review*, says he has attended upwards of three hundred labor cases, and he considered that drugs were often of much service, especially in pregnancy. In the vomiting of the latter, *ipécacuanha*, *kreosote*, and *apomorphine* were of great value. In heartburn and other forms of *dyspepsia nux vomica* was of service. During the fourth and fifth months a state of spinal irritation and nervous exhaustion was not infrequently met with, and here *sepia* and *actæa racemosa* act very satisfactorily. *Collinsonia* 1x was far preferable to aperients in the constipation of the latter months. During labor two medicines had served him well, *viz.*, *ignatia* and *pulsatilla*; the former in exhausted states of the nervous system, and the latter in uterine inertia or fatigue. For this condition, where in former days it was customary to give a drachm of ergot, he now gave five drops of the mother tincture of *pulsatilla*. For after-pains he administered *gelsemium*, two or three drops after each severe pain, and found it of much benefit. If this did not relieve,

and the pains were referred mostly to the back and thighs, actæa was given instead. In febrile conditions following labor, if originating in the uterus, veratrum viride tincture was the first medicine he thought of ; if in the mammæ, aconite or belladonna, or both. In inflammatory conditions, aconite, mercurius corrosivus, colocynth, bryonia, or nux vomica (in a high dilution) were called for, according to different indications. Injections of hot water with antiseptics were always of service. He believes the internal use of arsenic to be homœopathic to septic conditions.

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—Dr. Blake, in a discussion on the use of medicines in obstetric cases, said that tabacum relieved the vomiting of pregnancy, especially when associated with salivation. The heart-burn of pregnancy, was relieved by equal parts of carbo vegetabilis and bicarbonate of soda, crude, in teaspoonful doses.—*Monthly Homœopathic Review*, December.

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—In vaginismus, where no lesion can be discovered that involves the sexual organs, do not forget the possibility of *urethral fissures*. Dilate the urethra and examine carefully.

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—Grawitz (*Paris Med.*) calls attention to some cases of sudden death among children, who had previously presented no kind of disease, and who died with all the symptoms of asphyxia. In the case of a little girl of eight months, found dead in her cradle, the nurse was accused of having caused its death through negligence. The autopsy revealed that the child had died from asphyxia, and Grawitz referred this to the presence of an enormous thymus gland, which had compromised the large bronchi and vessels. In another case, a baby of six months, apparently healthy, remained suddenly without respiration, became blue, clinched its hands and died in a few minutes. At the autopsy there was found an enormous thymus gland, with two prolongation re-united at the median line and covered for the most part by the pericardial sac.

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—Inguinal hernia in the newly born or the very young is apt to recover spontaneously. When the short and straight canal

becomes longer and more oblique, in the course of a few years, and the amount of fat goes on increasing, the rupture may disappear; but all these predisposing factors never succeed in effecting a cure by themselves. This is accomplished only when the hernia is retained inside the abdominal cavity completely and constantly, by means of a truss, which must be worn for years. It must not be removed except when the baby is sleeping quietly. Trusses are uncomfortable in the beginning, and give rise to cutaneous irritation, particularly under the influence of urine. So much the more is it necessary to keep the truss clean, and always to select one which fits exactly without exerting too much pressure.

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—Ferrum phos. is called for in cholera infantum when the discharges from the bowels are frequent; the child becomes greatly reduced early in the course of the disease; there is stupor with red face, dilated pupils, rolling of the head, and soft, full-flowing pulse. Farrington relates a case with these symptoms (in which belladonna and sulphur were each given in turn, but failed) that was quickly relieved by ferrum phos.

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## ● GYNECIC ETCHINGS. ●

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—Attention has been called to the use of antipyrin in uterine cancer. In a case where the growth involved the cervix uteri, with severe lancinating pains, worse at night, occurring in an advanced stage of this disease, ten grains of antipyrin subdued the pain at once, though the beneficial effect of the drug was of short duration. This treatment was repeated as often as necessary, without the occurrence of any unpleasant symptoms attributable to antipyrin.

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—Dr. Geo. R. Southwick cites the following reasons as justifying the induction of abortion, when premonitory symptoms of eclampsia threaten in the albuminuria of pregnancy.



I. Delay is almost certainly followed by convulsions, jeopardizing the parent's life as well as that of her offspring.

II. Each day's delay causes further impairment of vision, from which the patient may not recover, and lays the foundation for a serious if not an ultimately fatal kidney lesion.

III. We are bound to act in the interest of the mother rather than the child, and the danger to the mother is beyond question.

IV. We are, then, not justified in waiting with the hope of saving the child when the patient is nearly seven months pregnant, as the fate of the child is always questionable at that period, and if the mother dies the infant often perishes.

V. The chances are better for securing a living child in another pregnancy than in the one so gravely threatened.

VI. Severe albuminuric retinitis, threatening permanent loss of vision, warrants the interruption of pregnancy, as eyesight cannot be restored, but another child may be born at a later period.

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—The question of the treatment of post-puerperal septic conditions by abdominal section, as suggested and practiced by Lawson Tait and others, is one of great importance. The reports of successful cases demonstrate to some extent that in laparotomy a new and very valuable means of combating some forms of a fatal puerperal disorder has been developed. Just now we are in want of more definite clinical experience on this point. Where peritonitis persists, in puerperal conditions, what little experience we have had points toward the conclusion that laparotomy increases the patient's chances, or, if there is a distinct purulent collection, that it affords her only chance.

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—Farrington described a little group of remedies for menstrual colic, among which *Cocculus*, *Pulsatilla*, and *Chamomilla* stand out very prominent. Under *cocculus* the colic is as if there were sharp stones rubbing against each other in the abdomen. There is very often with this colic excessive distension of the abdomen from flatus. The colic is especially liable to come on at night and awaken the patient. It is relieved by belching and returns again from the re-accumulation of flatus.

Chamomilla also has cutting colic in the abdomen, with dark menstrual flow, like cocculus, but is characterized by the peculiar irritability of the patient. Pulsatilla, likewise, has scanty and dark menstrual flow, with griping pains doubling the patient up, but is distinctive in its relief from cool air and in the mild and tearful disposition of the woman, to which it is particularly adapted.

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—Some cases of sore nipples evidently depend upon the condition of the child's mouth. A child with an aphthous mouth is apt to produce a sore condition of the nipple. The continued relations in these cases between the cause and effect make treatment difficult. In these cases we have succeeded best with glycerinum boracis (25 per cent. solution) applied freely to the child's mouth, and also to the nipple of the mother. The nurse is instructed to moisten the tip of the finger with the solution and carefully swab out the child's mouth during the morning bath.

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—In speaking of boric acid as an antiseptic it is necessary to remind the reader, however, that its use is not without danger. Dr. Jacob Plaut has made a number of experiments as to the danger of boric acid when used as an antiseptic, and has published his results (*Ther. Gazette*). These experiments appear to show that the results of the constant employment of boric acid, when brought into the peritoneal cavity or under the skin, results in many cases in rapid death if the quantities dissolved are large, or, if small, the final fatal effect is preceded by acute parenchymatous nephritis. The author does not seem to have established that the death of the various animals poisoned by boric acid was attributable to the renal inflammation, but his experiments are sufficient to show that boric acid is by no means the safe antiseptic which it was supposed to be.

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—Intra-pelvic inflammations present every grade of severity from a mere inflammatory spot to general peritonitis and abscess. In the mild grade of inflammation, similar in nature and extent to light attacks of pleurisy, there is a mere inflammatory spot,

giving some discomfort for a time and passing away without treatment, leaving a bare trace of adhesions behind. A higher grade is illustrated by those cases wherein, with subserous congestion, transudation of serum and exudation of plastic material obtain, forming an accumulation in Douglas's pouch. Following M. Bernutz's illustration by analogy, this condition corresponds to pleurisy with effusion. In the highest grades of inflammation all the intra-pelvic structures participate; the inflammatory process passes through the stages already described, and goes on to supuration, septic infection, and often to death. In the severe grades the products of inflammation are deposited upon the serous surfaces covering the uterus, ovaries, and fallopian tubes, leaving these organs imbedded and entangled in a mass of adhesions and bound down by bands of false membrane. As time goes on these layers of exudate pass through the stages of congestion to that of organization into connective tissue, with progressive contraction. The ovaries and fallopian tubes, being the center of infection, are the focus of inflammatory deposit. The ovaries, bound down and subjected to pressure, undergo inflammatory and degenerative changes. The fimbriated extremities of the tubes are destroyed and the entire tubes imprisoned in the exudate. The menstrual congestion, with continued recurrence, adds to the troubles by rendering tense these bands and strengthening and increasing the adhesions by constantly repeated congestion. Finally, the lesions entailed by pressure are increased by imprisoned secretions, and ovarian abscess and pyo-salpinx are common results.

—Staphisagria is sometimes indicated in prolapsus uteri, in states where the prolapsus is associated with a flabby condition of the abdomen. The whole abdomen is so relaxed, contents and parietes, that there is a sensation as if everything would drop out. The leucorrhœa accompanying this condition is yellow and excoriating. All this is the result of repeated pelvic congestions, from allowing the mind to dwell on sexual subjects.

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—Dr. H. I. Ostrom (*New Eng. Med. Gaz.*,) presents some pertinent remarks on the "Cause of Tubal Pregnancy" that approach very nearly to our own beliefs. In brief the author says: "Any-

thing that tends to destroy the ciliated epithelium lining the tubes will deprive them of their power to prevent the passage of the spermatozoa, and will so reduce their calibre that the ovum is arrested in its passage to the uterus. Here then we have conditions favorable to tubal pregnancy, and, pathologically, such conditions belong to inflammation.

"It is well known that gonorrhœa has a most destructive effect upon the epithelial lining of mucous surfaces, and it is also becoming a well-established fact that gonorrhœa plays an important part in the diseases of the fallopian tubes. I believe that gonorrhœa, frequently contracted from so-called latent gonorrhœa, is the principal cause of ectopic pregnancy."

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—Acute inflammation of the ovaries, uncomplicated by inflammation of the other pelvic tissues, is a very uncommon occurrence.

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—*Sabina* is indicated, especially in impending abortion about the third month, by a pain which commences in the small of the back and goes around and through the pubes, and by pains which run from the sacrum to the pubis. With these pains, there is a flow of bright red, clotted blood, increased by every motion.

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—The diversity of views on the nature of simple hypertrophic and ulcerative lesions of the vulva (those combined by Hugier in 1849 under the term *esthiomène*) has brought forth a paper by Dr. R. W. Taylor, which was read before the New York Academy of Medicine. Chronic inflammation, infiltration, and ulceration of the external genitals of women were considered particularly with reference to *esthiomène*. In conclusion the author sums up his views as follows :

1. That a large and perhaps the greater number of chronic deforming vulvar affections are due to simple hyperplasia of the tissues induced by irritating causes, inflammation, and traumatisms.
2. The chronic chancroid is a cause in a certain proportion of cases.
3. That many cases are due to essential and specific syphilitic infiltrations.

4. That other cases are caused by the hard œdema which often complicates and surrounds the initial sclerosis and perhaps gummatous infiltration.

5. That many cases are due to simply hyperplasia in old syphilitic subjects who suffer from chronic ulcerations of the vulva long after all specific lesions have departed.

6. That some cases also in old syphilitics are due to simple hyperplasia without the existence of [any concomitant ulcerative or infiltrative process, and seem to be caused by conditions which usually in healthy persons only result in vulvar inflammation.

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—It has been told to us that *Hamamelis* has often been used in pregnancy when varicose veins appeared over the abdomen, and when the patient could not make any motion without feeling a bruised, sore feeling. This characteristic of hamamelis, the great soreness of the part, is not the bruised feeling of arnica, nor the sensitive soreness of lachesis, nor the stinging soreness of apis. It is pointed out to us by Farrington as the sore feeling which belongs to venous congestion. The abdominal soreness of bryonia, of belladonna, and of rhus tox., is distinguished from that of hamamelis by the individual characteristics which mark the uterine symptoms of each of these drugs.

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## BOOK REVIEWS.

THE DIFFERENTIAL DIAGNOSIS OF TUBERCULAR LARYNGITIS.  
By H. H. CRIPPEN, M.D. (Reprint from the *Medical Counselor*, May, 1889.)

Contains carefully tabulated analyses of those affections that may be confused with phthisis laryngis.

ELECTRICAL DISTRIBUTION OF LIGHT, HEAT, AND POWER. By HAROLD P. BROWN.

This address, presented at the International Medico-Legal Congress, held in New York City June 4, 1889, gives some instructive comparisons as to the danger of the various electric light systems, and advocates the adoption of legal measures for their control.

**STUDIES IN INTESTINAL SURGERY.** By WM. B. VAN LENNEP, A.M., M.D. (Reprint from the *Hahnemannian Monthly*, vol. xxiv., No. 10.)

This small work contains the history of some original researches on the use of rubber rings in end-to-end union in enterorrhaphy, and is the more valuable for the clinical case that is given as an illustration of the way in which this method meets the requirements in resections of the intestinal tract.

**A LABORATORY GUIDE IN URINALYSIS AND TOXICOLOGY.** By R. A. WITTHAUS, A.M., M.D. William Wood & Company, New York.

The second edition of Witthaus's work contains some features that commend its use as a very handy laboratory companion. To those who have been using the heavy, unwieldy reference books, when doing laboratory work, this guide to urinary analysis will be a great comfort, and, besides this, they will find many little practical hints on laboratory technique that will greatly facilitate their work.

**THE CLIMATE OF SOUTHERN CALIFORNIA IN ITS RELATION TO RENAL DISEASES.** By P. C. REMONDINO, M.D. (Reprint from the *Southern California Practitioner*.)

The uniformity of the climate of Southern California, especially in the vicinity of San Diego, receives careful consideration by the author with regard to its influence on renal disorders. The relief which so many sufferers from these troubles experience is attributed to the uniformity of temperature, of humidity, and of the velocity of the wind. There also exists here a spring of water which gives nearly the same analytical results as that of Waukesha, Wisconsin.

**FIBROMES UTÉRINS: LEUR TRAITEMENT PAR L'ÉLECTROLYSE (method Apostoli), ET LEUR ÉLIMINATION FRÉQUENTE SOUS-MUQUEUSE PAR L'ACTION DE L'ÉLECTRICITÉ.** Par Docteur LA TORRE (de Rome).

The author, in this reprint from the *Archives de Tocologie* (December, 1889; January and February, 1889) reviews and augments his previous article, bringing many facts to support his advocacy of Apostoli's method as superior to hysterectomy in its mortality statistics, as well as in its general effects. In the midst of all the assertions of the inefficacy of electrolysis in uterine fibromata, he admits that Apostoli's method cannot yet be considered a *radical* treatment for these tumors, but he also brings forward abundant testimony to show that the treatment by electrolysis is not dangerous, and that it has, among nearly all the women treated, a stimulating effect very favorable to the general nutrition and to the recuperation of the vital forces.



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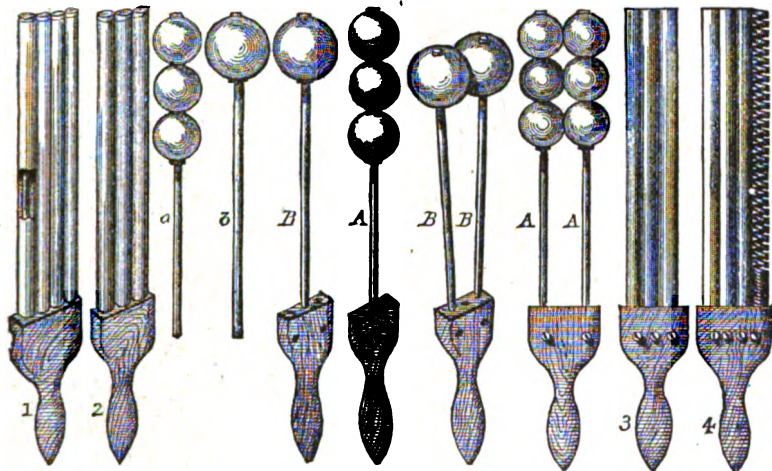
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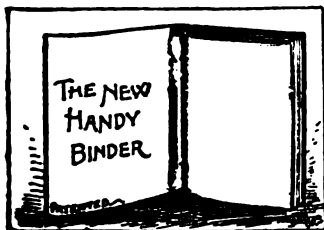


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DISEASES OF THE UTERINE APPENDAGES.

BY

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NEW YORK,

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New York.

A very considerable proportion of the diseases of women that come into the hands of the surgeon are associated with, or dependent upon, some derangement of the uterine appendages. For if we exclude uterine tumors, and displacements, and the diseases of the endometrium, we have left the large class of ovarian, tubal, and broad ligament tumors; the various forms of inflammation to which the tubes and ovaries are subject, and the vast variety of affections of the pelvic cellular tissue, dependent for the most part upon an extension of disease from the appendages. The division, therefore, of the diseases of women into diseases of the uterus and diseases of the appendages, has a clinical as well as a physiological meaning. But, as in other branches of study, boundary lines are not absolute, for we constantly find one division encroaching upon the other.

This becomes apparent in the diseases of women, as we proceed with their investigation, for frequently, when the uterus is the first organ to attract attention, a closer study of the case, and more accurate methods of diagnosis, will show this to be secondarily involved, the true disease residing in the appendages.

A reason for this doubtless exists in the different functions that these two parts of the reproductive system perform. In general terms, it may be said that the uterus is an entirely passive organ, having no independent activity. Its function is placenta formation, but only under the stimulus of the appendages is this function performed. The proof of this is found in the fact that when the appendages are removed, or become through disease or age inactive, the uterus no longer makes an effort toward the formation of a placenta, but undergoes a process of gradual involution, returning to the virginal type. From analogy, we would therefore expect to find diseases of the uterus more passive in character than active, less frequently the result of primary than of secondary derangements; and such in fact is the case.

Let us first consider the diseases of the uterus that are dependent upon derangement of the appendages. These are for the most part connected either with over-growth—sub-involution, or under-growth—super-involution. For example, the sub-involution of the uterus so frequent after child-birth. In this state, the organ has not returned to its ante-pregnant size, and one of the first indications we have of the condition is the early return of menstruation, especially significant, if the mother is nursing her child. What actually exists in these cases? The uterus is not allowed a sufficient time to rest, or to pass through the physiological changes of involution; it cannot fold up, but under the stimulus of the ovaries begins its placenta formation before it is ready to again set going the process of gestation. As a consequence, the uterus is kept in a con-

stant state of excitement, and passes into a condition of chronic over-nourishment. The displacements, inflammations, and ulcerations to which this gives rise, are but too familiar to every practitioner.

There would also seem to be some connection between the growth of myomata, especially of the nodular variety, and the functional activity of the ovaries. These tumors are really circumscribed outgrowths of uterine tissue, and cease to develop when the appendages are removed. The soft-œdematous myomata are apparently less influenced by the menstrual function, but even this variety of tumor may well be looked upon as influenced by the activity of the ovaries.

As another instance of over-action of the uterus dependent upon ovarian derangement, we may refer to the undoubted relation that exists between a certain form of small cystic ovary, and intractable menorrhagia.

These cases have until quite recently been regarded as uterine growths, myomata, or endometrium developments, but the hæmorrhage exists when none of these conditions are found, and when the only abnormal condition discoverable is an unnatural hardness, and slight enlargement with some tenderness of the ovaries. The glands when removed are seen to be cystic, and sometimes slightly cirrhotic, but not otherwise diseased.

The connection between the ovaries and the hæmorrhage we are able to trace, but the peculiar pathology of the ovary that exerts such an influence remains to be discovered. It would seem to be an excess of action, causing an imperfect but almost continuous attempt at placenta formation. In one case that I operated upon by removing the appendages, the menorrhagia, or rather metrorrhagia, was accompanied by a frequent discharge of deciduous membrane, showing the process that was going on within the uterus. This case was an interesting one. The lady, about thirty years old, unmarried, was sent to me from the country. She had been

flowing almost continuously for five years. Every local means and internal treatment had been resorted to without success. I found the uterus large, and the os open. No special ovarian tenderness, and no uterine tumor. The uterus was thoroughly curetted. For three weeks the hæmorrhage ceased. It then gradually returned, and in six weeks from the operation was as profuse as before. I curetted the uterus a second time, and cauterized it; but the result was as before. I then removed the appendages, making my stump close to the uterus, with the effect of completely arresting the flow. The ovaries when examined were found unnaturally hard, and cystic. They were also found firmly adherent behind the broad ligament, giving evidence of previous inflammation, but her history did not include such attacks.

At the other end of the scale are found derangements resulting from super-involution of the uterus. Here we meet, as a congenital disease, with the infantile uterus, a state of the organ that gives rise to much suffering during the whole of menstrual life. Nothing relieves the dysmenorrhœa, for there is a constant effort on the part of an undeveloped uterus to perform the function of fully developed ovaries. Of these cases two facts are apparent. *First*, the women should not marry, for there is no reason for believing that married life will develop a congenitally infantile uterus, and there is every reason to expect that marital life will increase ovarian excitement, and thereby augment the work thrown upon the uterus. *Second*, that at present we know of no treatment capable of developing the uterus, and therefore the only cure is to remove the appendages. The subjects are already sterile, and have nothing to lose, but much to gain, from the operation. Of course it will be understood that I advocate this radical treatment only for well pronounced cases, in which the diagnosis admits of no doubt, and after every other means have been tried, and failed to improve the condition.



An acquired super-involution, developing after childbirth, closely resembles the congenital infantile uterus, and is also probably associated with a like folding-up of the appendages, for it has been observed in these cases that menstruation early becomes scanty, or ceases. The changes that take place are somewhat different from those that belong to the change of life, for rarely, especially in women who have born children, is the infantile type of organs reproduced, the process more closely resembles atrophy than a return to a primitive type of organ. The circumstances, however, of the acquired super-involution can scarcely call for the same operative measures that I have advocated as a last resort in the treatment of the congenital variety of infantile uterus.

The diseases of the uterine appendages to which I wish especially to draw attention are not necessarily associated with diseases of the uterus, but belong to a class that, both because of its pathology and the importance and definiteness of its symptoms, deserves to be studied separately. These diseases of the appendages are chiefly inflammatory, or the result of inflammation, and have not until quite recently been well understood, but the knowledge obtained even thus far has done much to elucidate hitherto obscure pelvic disorders, for we have learned to look to the ovaries and their ducts as the active parts in many of the diseases of the reproductive organs.

To form a correct estimate of the clinical value of ovarian and tubal pathology, we must disabuse ourselves of the impression that the severity and gravity of the case of necessity increases in proportion to the gross lesion. That is to say, because an ovary or tube is but slightly enlarged, or is more sensitive than normal, or presents to the touch conditions but illy defined as pathological, we are not to conclude that these organs may not be the ones at fault; for I have removed an ovarian tumor no larger than an English walnut, the seat of so much pain as to render life almost

unendurable, and I have removed ovarian tumors that weighed almost one hundred pounds, that caused no other inconvenience than arose from their size and weight. Only a short time since, I removed the appendages of a lady thirty-three years old, whose life had become one of prolonged suffering. Before the operation, I could discover no great lesion of the appendages. The ovaries were a little harder than normal, and the appendages slightly displaced, but I have found apparently similar conditions in many cases in which the reproductive organs gave no indication of derangement. In this case, the symptoms pointed to the ovaries as the seat of the suffering. Both appendages were found densely adherent. The right ovary,—the one first affected—contained a fibrous tumor, about the size of a large pea, exceedingly hard, almost cartilaginous, and several cysts, filled with a dark, semi-fluid substance. The left ovary—the one secondarily attacked—was a counterpart of the right gland, though not quite so far advanced. Complete relief has followed the operation,—a relief, I venture to say, that could not have been attained by less radical treatment. Similar experiences are by no means unique with laparotomists, for we not infrequently meet with conditions that we are able to attribute to the appendages, when we can discover no gross pathology in these organs. As a rule, however, experience and care in examination will greatly reduce the number of such cases, for the educated finger is frequently able to detect even a suggestion of disease.

A word further concerning small cystic ovaries. There is little doubt that in them we find a process of degeneration, capable of interfering with ovulation, productive of more or less prolonged suffering, and very probably the starting-point of some of the most difficult ovarian tumors to remove, the partly solid, true ovarian cystomata. The relation of these diseased ovaries to reproduction is at present a matter for speculation, but I cannot but

feel that perfect ovulation is impossible in organs so seriously degenerated.

Inflammation of the ovary, both acute and chronic, with the quite rare formation of abscesses, is among the most frequent diseases of the female reproductive glands. In some instances it is probably nothing more than an exaggeration of the menstrual physiological congestion, and usually, if not always, originates in some accident of menstruation, as a cold, over-exertion, or shock, that interferes with normal ovulation, or the case may be idiopathic. These causes may not result in immediate inflammation, but the returning periods develop the irritation already generated.

We are all familiar with the clinical history of oöphoritis. In its acute form, the treatment is usually successful. The chronic form may prove so intractable as to necessitate removal of the inflamed gland. Such instances are extreme cases, but the operation may be called for, not only to relieve local suffering, but to control uterine hæmorrhage, for the irritation of a chronically inflamed ovary is capable of imparting an over-functional activity to the uterus, resulting in a more or less constant hæmorrhage from the endometrium.

The fallopian tubes like the uterus are passive organs, as far as their function is concerned. They are simply carriers, to convey to the uterus the female element of reproduction. In agreement with this physiological fact, we find that the majority of tubal affections arise from an extension of disease, either from the ovaries, or more frequently from the uterus. They for the most part may be classed among inflammatory diseases, that have their origin in an extension of endometritis along the fallopian tube, or the passage of gonorrhœal pus toward the ovary. Whether at the same time the lining of the uterus must be effected in like manner, is difficult to determine, but probably such is the case.

Within the past few years much has been said concern-

ing the three principal diseases of the tubes, salpingitis, pyosalpinx, and hydrosalpinx. There is, however, no reason for believing that these diseases are either more frequent or more severe than formerly, or that the conditions that are known to precede their development are more prevalent now than they were fifty years ago. The present frequency of tubal diseases is probably wholly due to increased skill in diagnosing pelvic disorders. But a few years ago, the diseases peculiar to women were made to conform to a diagnosis of uterine displacement or inflammation, cellulitis, and some degree of inflammation of the ovaries. The fallopian tubes were left out of consideration. Now we know that these canals are affected in a large proportion of the diseases of the female pelvis, and that, either alone or in connection with inflammation of the uterus or ovaries, they constitute very important structures in the diseases of women.

Simple inflammation of the fallopian tubes—salpingitis—is probably the initial process in all the inflammatory diseases of these organs, for it is more than likely that the tubes share in any congestion or inflammation that develops in the pelvic organs. But that every case of salpingitis progresses to the proportions of requiring more than the simplest treatment, is not supported by clinical history. Menstruation is accompanied by a perfectly physiological tubal congestion, and the same degree of local disturbance may occur from other causes, and pass off without giving sufficient indication to call for treatment. Many cases, however, do not terminate so favorably, but go through all the stages of inflammation to suppuration, and finally develop abscesses.

In common with other epithelial coverings, that which lines the fallopian tubes is prone to over-activity, and there is thus developed catarrh, a result probably always found where there is any considerable inflammation. As long as the tube continues patulous, allowing the over-

secretion to flow into the uterus, we have to deal with no more serious condition than inflammation, but in the majority of cases, the tumefaction that accompanies catarrh closes the canal, and we have to deal with an inflamed, occluded tube.

Beyond a varying degree of pain,—sometimes very severe, at others not exceeding local uneasiness,—this inflammation, and even occlusion, may continue with only illy defined subjective symptoms, until the next menstrual period, when the condition, especially if there is occlusion, admits of an unmistakable diagnosis. An examination will then show the tubes to be enlarged and rope-like, extremely sensitive, and the seat of throbbing pains. The uterus is movable, but especially lateral motion causes an increase of suffering from the tension which it brings upon the inflamed structures. If the case is acute the evidences of inflammation will be confined to the appendages, but if at all chronic, the pelvic cellular tissue will be found to sympathize, if not to participate, in the tubular disease.

It now seems to be quite conclusively established, that the principal cause of salpingitis is gonorrhœa, but that other causes may give rise to this disease is equally clear. For while it is found most frequently in women who have been exposed to the gonorrhœal infection, acute, or latent, undoubted cases have been known to exist in virgins, and in those presenting no history of infection. It is probable that any inflammation of the endometrium is readily conveyed or communicated to the fallopian tubes, and we know that all ages and conditions of life are subject to inflammatory diseases of the uterus. In the etiology of salpingitis, we must not overlook the effect of exanthematic diseases upon the reproductive organs. That this is very considerable we cannot doubt, nor can we refuse to believe that this effect may remain latent for a length of time, and not develop into prominence save under some acute exciting cause. For example, a young girl may have

scarlet fever. No thought is given to the uterine appendages until puberty, and even then the unhealthy establishment of this perfectly natural function is not connected with the disease of early childhood. In many cases of amenorrhœa and dysmenorrhœa, I believe the cause lies quite as frequently in the tubes as in the ovaries, and the part played by the exanthematic diseases in tubal disease is, I believe, very considerable.

The treatment of salpingitis will be the treatment of inflammation generally. Rest, hot douches, possibly iodine, and glycerine tampons, and such remedies as belladonna,—I sometimes use the glycerole of belladonna on the tampon—bryonia, and merc. corr. will be found useful, but I must confess that I have learned to place more confidence in absolute rest with careful packing of the vagina, than in medicines, unless indicated by general symptoms. I say packing the vagina, for my method of using what is ordinarily called a tampon differs from that generally adopted. I have abandoned the use of absorbent cotton, because it quickly becomes solid and thus serves to irritate by pressure, and have substituted ordinary cheese-cloth. This I have boiled, which renders it quite absorbent, sufficiently so to take up any medicinal agent required. I cut it in strips, and these I pack, or rather place around the cervix, leaving one end at the vulva, for removal. All we require in these cases, or in the majority of cases where local treatment is called for, is to give gentle support, at the same time that we apply the desired medicine. I find that I accomplish both of these indications better with the cheese-cloth, than with the formerly used absorbent cotton, or even wool covered with cotton, a form of vaginal tampon that I advocated some years ago.

From salpingitis, we pass by continuous pathological stages to pyosalpinx. It is probable that hydrosalpinx may occupy a position between inflammation, and the formation of pus in a limited portion of the tube, but not every case of

hydrosalpinx terminates in pyosalpinx, nor does every abscess of the fallopian tube originate in an over-secretion of serum.

When the catarrhal inflammation reaches such a degree as to close the tube, or if the primary inflammation does not terminate in catarrh, but passes through the several stages that belong to inflammation in other structures, the conditions are favorable for the development of pyosalpinx. That is, the calibre of the tube is destroyed at two points, and pus forms in the inter-space.

Now I believe that, in the majority of instances, we are made aware of tubal disease by this very circumstance of occlusion. For as long as the discharge, catarrh, serum, or pus, has a vent into the uterus, there are frequently no symptoms, beyond those of local irritation, to mark disease of these structures.

Occasionally we meet with cases of pyosalpinx that discharge into the uterus at irregular periods. Such cases are marked by gradually increasing pain during the accumulation of the fluid, and very marked relief when the discharge has taken place. In such instances the stricture cannot be a complete one, for it yields to pressure from behind. Rarely, a pyosalpinx discharges into the intestine, and for this to occur some very peculiar relations of the parts must exist. About one year ago I operated upon such a case. The fimbria adhered to the colon, completely sealing the tube, and the tube itself was occluded at the ampulla. The abscess was a large one, and had discharged several times into the bowel. I removed the appendage, the patient making an excellent recovery.

Occlusion of the fallopian tube, with consequent accumulation of fluid, gives rise to some very interesting changes in the anatomical arrangement of the pelvic organ. The tubes may indeed be found in almost any position, relatively to the uterus and ovaries. When greatly enlarged, the uterus being normal, they generally lie well behind the

latter organ, but I have found them in front, against the bladder, and in one instance, where the uterus was somewhat enlarged, both appendages lay in the pouch of Douglas, the fundus being firmly adherent over them. In this case the first impression upon entering the abdomen was that the appendages were congenitally absent, but by tracing the tubes outwards from the uterine cornua, I was able to discover their situation, but before they could be removed, I found it necessary to separate the adhesions of the fundus, and anteflex the uterus. In two other cases I found the fallopian tubes below and posterior to the ovaries, their relations having been entirely altered, but it is impossible to say whether this was caused by the distended tube, or was congenital.

There is reason to believe that a considerable number of damaged appendages are owing to some developmental defect, to which is added local inflammation, an exciting cause that under other anatomical conditions would not be productive of the same serious consequences. It is well known, for example, that in embryonic life the fallopian tubes as they descend into position acquire spiral twists, which close their calibre. At puberty these twists should be effaced, and the tubes become straight. It requires little demonstration to show the effect that the continuance of the embryonic twisting would have upon the functional activity of the appendages, or to point out the connection between it, and the diseases of the tubes that are associated with a retention of fluid. For while the calibre of a twisted fallopian tube may be quite sufficient to transmit the ovum to the uterus—though the opposite condition may exist unsuspected, the mature ovum dropping into the abdominal cavity—it is very possible for even a slight catarrh of the lining epithelium, or a simple congestion, to result in occlusion. I believe that these congenitally twisted tubes are the ones we are most frequently called upon to remove. They are the ones that most readily become tortuous, and



twisted upon themselves, and that lie low down behind the uterus.

Fallopian tubes containing pus, that occupy that position, are beyond the help of medicine, or local treatment. While they remain at the side of the uterus, and retain their natural outward direction, there is a prospect that they will discharge through the uterus, and by means of local treatment may be restored to health; but if the tube is twisted before the pathological process is established, it will not remain at the side of the uterus but will be mechanically displaced, either behind or in front of that organ. In either of these situations, it contracts adhesions, and, as it enlarges by the accumulation of pus, drags down the ovary, which together with the tube thus lies upon the rectum, a source of constant pain and suffering.

The causes of pyosalpinx are much the same as those of salpingitis. Any inflammation of the uterus may spread along the tubes, and there induce occlusion and suppuration, but it is probable that the simple inflammation is the expression of a mild inflammatory process, while the graver disease is the development of a correspondingly severe process.

Among the known causes of pyosalpinx, gonorrhœa occupies an important place. The disease spreads from the uterus to the tubes, and, if happily it does not gain access to the abdomen, there quickly induces sufficient inflammation to occlude the tubes and develop pus. The usual history of these cases is, *first*, gonorrhœa in the male, that is believed to have been cured, but which reappears from time to time in the form of a slight moisture at the meatus. *Second*, either one child soon after marriage, following which there has been a constantly increasing pelvic discomfort, with painful menstruation, and finally dyspareunia. Or the pelvic derangement may develop soon after marriage, and the woman early become sterile.

Next in frequency to gonorrhœa as a cause of pyosal-

pinx is probably some form of septic poison, introduced into the system during the lying-in period, or the result of some operation-upon the uterus or external genitals. In such cases, while the history of infection will differ from that due to gonorrhœa, the subsequent course will be much the same, but I believe, if anything, less virulent.

There are, however, cases of pyosalpinx that cannot be traced to either gonorrhœa or septic infection, occurring in unmarried women above suspicion, and in married women whose husband's veracity does not admit of being questioned. Only this morning an unmarried lady, under thirty years of age, whose social standing disarms suspicion, consulted me for pelvic troubles. An examination showed an entirely virginal condition, but I found her to be suffering from a well-marked pyosalpinx, apparently so near rupture that I do not consider it wise to delay its removal. Such cases, and my case-books contain a number of similar ones, will of course be regarded as idiopathic, but this does not advance us far in the etiology of pyosalpinx, for beyond doubt there is some cause for the inflammation, and formation of pus. I am inclined to the opinion that these obscure cases are associated with some congenital defect, possibly the spiral persistence of the tube, that acts as a predisposing cause, making the appendages more susceptible of slight local derangements and functional irregularities than they would otherwise be. Certain it is, that we meet cases of idiopathic pyosalpinx with sufficient frequency to guard against a routine-diagnosis that involves unchastity, or that reflects upon the faithfulness of married life. While I am uncompromising in my denunciation of any man who would knowingly expose the woman he desires to make the mother of his children to the consequences of his own impure life, it behooves us as surgeons, and as members of a profession that above all others holds the happiness of the home and public morals in its keeping, to study these diseases of the uterine appendages well, and to reflect that they may arise

without definite cause, and that in the married they may result from an early gonorrhœa in the husband, suppressed, but not cured.

The symptoms of what Mr. Tait has very properly named damaged appendages, for in point of fact the ovaries are usually implicated when the tubes are badly diseased, are sufficiently well known to call for only a passing notice. There can usually be elicited a history of one or more attacks of pelvic inflammation, though the history may be rather obscure, partly because women are accustomed to suffering connected with menstruation, and therefore do not note even a considerable increase of pain, and also because pus may form in the pelvis and in the fallopian tubes without the symptoms that usually attend suppuration. I have removed a very extensive pyosalpinx containing a large quantity of pus when nothing in the history of the case indicated that suppuration had taken place; and therefore, while the chill and temperature which we recognize as indicative of the formation of pus will, when present, be of value, their absence is not to be considered of much diagnostic importance.

Pain, especially pronounced before menstruation, is pathognomonic of occluded tubes, but there is always a dull aching pain in the ovaries, with backache and local sensitiveness. The pain in the tumor is frequently aggravated during stool; especially is this true of the left appendage, and I have had patients complain of much aching and soreness in the sacrum during a movement from the bowels. In these cases I have always found the enlarged tube well dislocated behind the uterus, and sensitive to the slightest touch. Such cases are also always accompanied with dyspareunia. A peculiar stooping position when standing or walking, and a rigid method of holding the body when stopping, as if to resist any jar, are also quite indicative of pyosalpinx, but the only trustworthy signs are to be obtained from a vaginal or bi-manual examination. This

shows the damaged appendage to be dislocated behind the uterus, where it lies as an extremely sensitive sausage-shaped body. The whole pelvic floor may be more or less hard, and the uterus fixed, but usually this is found only in the severer forms of pyosalpinx. Ordinarily the uterus is quite movable, and to the unpracticed finger gives the impression of taking the tubal tumor with it, but careful examination will always show a clear line of separation between the distended tube and the uterus, and that the close connection between these is owing to the narrow space in which they lie, and the tension which the dislocated organ makes upon the broad ligaments. I have never found a rectal examination necessary to establish a diagnosis of pyosalpinx, but possibly some doubtful cases could be made clear by this means of reaching a pelvic tumor.

The treatment of pyosalpinx may be palliative, or radical; the cure can, I believe, only be effected by radical operative measures. For the palliative treatment, rest, vaginal packing with glycerole of belladonna, or boro-glyceride, possibly iodine, will answer best, with such internal remedies as valerianate of zinc, lachesis, and calcium sulphate. But while with such treatment I have succeeded in rendering patients comfortable, I have never effected a cure. And patients so treated for several years, have finally been obliged to submit to an operation, in a less favorable condition than they would have been had they yielded to my earlier advice.

Of radical means, I without hesitation give my voice in favor of a laparotomy. I have never used either vaginal puncture or electricity, but I have seen both methods used by other surgeons, whom I have every reason to believe were masters of the particular treatment they advocated, and I have yet to see a case cured by either of these methods. As long as the abdomen can be opened, and the appendages removed with as low a mortality as we can now show,

and with as rapid cures, I am not inclined to try less certain methods, or methods that I am confident increase the risks and difficulties of an operation that unfortunately is frequently a last resort.

42 WEST FORTY-EIGHTH STREET.

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## COMMONPLACE OBSTETRICS.

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BY

F. W. SOUTHWORTH, M.D.

TACOMA, WASH.

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A comprehensive survey of the field of obstetrics discloses scarcely a point upon which one may base an article and label it original. The *theory* of obstetrical science always remains the starting-point, the *practice* the road to proficiency and absolute knowledge. The theory has been well studied and well learned during recent years, but the practice still discovers to the observing accoucheur facts previously undisclosed and of great clinical importance. We are not yet out of the realm of speculation, for various theories occupy their place for a time in the medical mind. The most important of these of course is anti- and asepsis. The busy every-day, all-around doctor has little time to devote to the practice of the exacting conditions of antisepsis, and even neglects asepsis. Of the two I am inclined to favor the old proverb, "An ounce of prevention is worth a pound of cure," and believe asepsis of more importance than antisepsis. According to Dr. Winterburn's observations at the Sloane Maternity, the showing of Listerism offers little that might justify that method. (*Vide* Jan. HOM. JOUR. OF OBSTET.). While the impregnated air of the hospital may antagonize microbes it doubtless also vitiates it, since the offspring of these cases do not seem to thrive (*vide* same article).

As the opinions of men differ on all subjects in some points, from my experience I have learned to differ in the practice of medicine and surgery from those of many of my colleagues. I believe it is an *art* as well as a *science*, and like Sir Joshua Reynolds, who said, "Artists are born, not made," I am inclined to the idea that the saying applies equally well to the successful practitioner of medicine and surgery. How few possess the delicate, sensitive touch—the eyes in the fingers—that diagnosticates a position or presentation, or a pathological condition, with almost unerring certainty; the finer sense of hearing, which in its acuteness penetrates deeply into the heart of the matter. Ofttimes, as Dr. Winterburn says, the "still, small voice" is the guiding hand.

But I only intended giving clinical experiences of everyday practice, and not to criticise or philosophize.

My first case was a primiparæ and forceps delivery, and it seems the saying that "a man's first case determines the subsequent ones," was verified in my experience, for I have had but few since *au naturel*. Perhaps I may be at fault in this, however.

The preparatory treatment of the parous woman I have rarely undertaken, since few will take remedies in anticipation of confinement, except in case of threatened abortion or miscarriage. In such cases I enjoin rest in bed during continuance of the usual menstrual period, and the administration of viburnum prun. *ix*.

As far as possible, in all cases I insist on a vegetarian's diet, as I believe it gives bone and vigor to the individual and promotes digestion and sleep, rather than the indulgence in animal foods. Regular daily walks, and bathing to the extent of cleanliness only, are also adjuncts. I have tried macrotin a few weeks previous to confinement, but cannot say that I have seen any marked results in softening the parts or facilitating labor.

My conduct of labor I try to simplify as much as possible,

paying due regard to cleanliness. I have never used antiseptics of any kind, unless it be a few drops of carbolic acid.

When called to a case of labor I make an immediate examination of abdomen with the stethoscope and manual palpation, and as far as possible by those means determine the position of the child; then I pass to a digital examination per vaginam and make out the presentation and condition of the parts.

If the pains are absent, weak, and ineffectual, I have the woman walk about the room, and at the same time give *caulophyllum* ʒ or 1x in hot water in teaspoonful doses every fifteen minutes. I have never had it fail me in establishing good labor pains in a short time. As labor progresses for rigidity of the os I give 20 drops *gelsemium*. ʒ in a tablespoonful of hot water, and sit the patient over a vessel of steaming hot water. I rarely have to repeat the dose. Have used the *gelsemium* in potencies, but prefer the tincture. *Cimicifuga* acts well sometimes after *gelsemium* fails.

After complete dilatation of the os I rupture the membranes and assist the woman by a sheet bandage over the abdomen. Giving one end to the nurse we draw it taut during pains. After a reasonable time, say four hours at the longest, if little progress is made I resort to the short forceps (Hale's pistol handle) when practicable, and deliver under chloroform. I cannot think it right to allow a woman to suffer for hours until exhausted, to deliver a large head which may be relieved in a few minutes by chloroform and the forceps. If the parts are pliant and yielding no harm can possibly occur.

For rigid perineum, he who tries the following will never be without it,—I consider it indispensable and infallible :

R. Chloroform.....	.....	℥ ii.
Æther sulph.....	.....	℥ i.
Cologne.....	.....	Δ j.
M. - Sig. Apply locally.		

It acts quickly and well. I have had large heads pass

perineums which seemed impossible without extensive rupture, without the beginning of a tear even, when this preparation was used. It was first recommended by Dr. Wm. V. Howland.

I now administer half a teaspoonful of ergot, and after completion of the second stage of labor I wait until pulsation has ceased in the cord, then ligate and cut it, tying both ends. (I think it safer to tie the umbilical end, as I had a case of a child who nearly bled to death through this omission.)

The child is now passed to the nurse, who quickly and thoroughly oils it with pure olive oil and rolls it up in a soft flannel blanket (after she assists me through the remaining attentions to the mother, it is then washed and dressed).

In ten or fifteen minutes after the cord is cut, I remove the placenta by gentle, firm, steady pressure—more of a grip—on the fundus of the womb, while I make traction on the cord with the other hand—right or left according to my position (I prefer the right side of the patient).

In retained placenta, I introduce the lubricated hand and peel it from the uterine side.

In reference to the use of anæsthetics: I use chloroform, allowing the woman to inhale it from a handkerchief herself when the pains are very severe. I am certain it lends courage and strength, for the pains become more expulsive and bearable.

After labor I apply a cloth saturated with hypericum perf. 1-4 over the pudenda, and usually administer bell. hypericum internally. This quickly relieves all soreness from the parts and also acts in the capacity of an antiseptic. Later on I use vaginal injections of a weak solution of calendula, glycerole, and a few drops of carbolic acid, a solution which is soothing and healing, as well as grateful to the patient.

For after-pains an occasional dessert-spoonful of vinegar, or *cimicifuga racemosa* 1x, or *xanthoxilin* 1x.

If the bowels do not move before the fourth day after



labor, I use an enema of warm water, or a glycerine suppository.

I usually have the child applied to the breasts as soon as the mother has had a rest and been washed. If there is no milk on the second day after confinement I generally direct the child to be fed a little condensed milk (Eagle or Highland brand). I favor the waiting for milk to appear in the breasts, but some children would starve if they were obliged to wait over two days.

In case the child does not readily urinate, I apply a hot moist flannel over the region of the bladder, which generally has the desired effect.

To relieve the bowels of meconium an enema of equal parts of glycerine and water, if necessary. I don't think a teaspoonful of castor oil in such a case, were it obstinate, at all reprehensible practice. The meconium is really a foreign matter and should be gotten rid of.

In case of deficient milk in the mother, I have used sticta 1x, and calc. carb. 3x, with good results; but in case the mother cannot nurse the child, I find in cow's milk and lime water, Peptonized Milk powder, Mellin's Food, Imperial Granum, condensed milk, the most important. Have used nearly all others, but prefer these.

I usually give my patient a week's daily attention after delivery, after which, all being well, I leave her in the hands of the nurse, with directions not to get up for another week.

The diet in these cases I make as nourishing and digestible as circumstances will allow.

This, then, is my usual course in every-day practice. Of course, there occur special cases which demand special treatment, but in this article it was my intention to give my treatment of commonplace cases, only. I think it differs in many respects from the published experience of my colleagues, but I can say my success has been flattering, and I have the thanks of my patients as well as their dollars, in grateful testimony of my services.

## HYGIENE OF THE EYES OF CHILDREN.

BY

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*(Continued from page 537, Nov., 1889.)*

*Hygiene with regard to the Anomalies of Refraction and Accommodation.*—Of all the errors of refraction myopia is the most frequent. According to statistics it is met with in the proportion of twelve to one of hypermetropia. It is then a most important subject for consideration, and especially is it of interest here; for preventive measures adopted during early life can avert to a great extent the

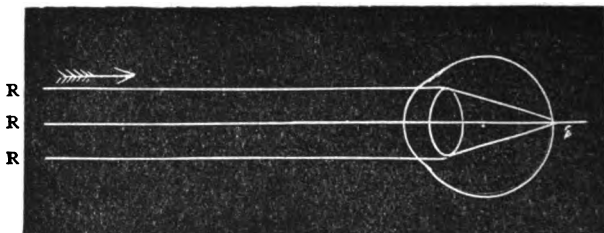


FIG. 1.—THE EMMETROPIC EYE. R. R. R., rays of light from infinity, have their focus on the retina.

development of many serious troubles that arise from the tendency to an increase in the degree of myopia.

In the myopic eye the parallel rays of light that proceed from infinity,\* in place of being focused on the retina as in the emmetropic eye or normal eye (Fig. 1), are reunited in a luminous point *in front* of the retina. This default of proper focus may arise from two causes: (a) From an abnormal elongation of the antero-posterior axis of the eyeball (Fig. 2). (b) From an increase in the refractive

\* In ophthalmology infinity is considered, for practical purposes of measurement, as 5 metres distant before the eyes.

powers of the ocular media. The first of these conditions, axial myopia, comes, as we shall see farther, particularly within the scope of this work and is a frequent affection. The second condition, commonly called myopia of curvature, is rare,\* and, being caused by augmentation of the curvature of the different refractive surfaces of the eye, demands treatment rather than prevention. Among its causes are keratoglobus, displacement of the crystalline lens forward, spasm of the accommodation, etc.

Let us now examine axial myopia, and see what need for precautionary measures.

This elongation of the axis of the eyeball is frequently

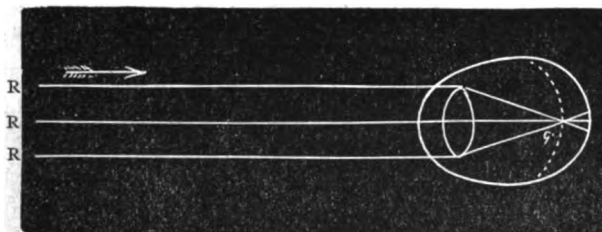


FIG. 2.—THE MYOPIC EYE. R. R. R., rays of light from infinity, are focused before reaching the retina.

hereditary, and, being a hereditary congenital affection, the lengthening of the antero-posterior axis is also accompanied in many cases by an inherited thinness, or a lack of resisting power, of the coats of the eye. Now, with the eye in form of an oval instead of a sphere, as in the normal eye, with a loss of resisting power of the ocular tunics, and with, it may be, a vicious insertion of the external muscles, there is a constant tendency to an increase of the length of the antero-posterior axis, when the time comes for the child to make prolonged efforts of convergence and accommodation. This increase of the length of the eyeball, under the combined tension of accommodation and convergence, may become so great as to cause separation of

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\* Spasm of the accommodation forms the exception to this rule.

the deep structures of the eye by the gradual pushing back of the membranes into the form of a staphylomatous excavation at the posterior pole. In this manner, from a slight elongation of the axis of the eyeball at birth, the myopia, in place of remaining stationary, may become progressive and can attain a high degree, causing the development of grave disorders.

Given a child, then, with a congenital ovoid formation of the eyeball and with ocular membranes abnormally lacking in resistance, there devolves necessity for surrounding the educational period of life with every hygienic measure that can preserve the eyes from this progressive elongation of the antero-posterior axis of the eye.

*Hygiene of Myopia.*—First of all, the general health needs supervision. Under the debilitating influence of anæmia, or during convalescence from exhausting diseases, the ocular tissues partake of the general weakness, and near work for the eyes must be prohibited until the system resumes its full vigor. Children of weak body, especially those predisposed to myopia, need more than ever to be surrounded by hygienic measures, looking toward the establishment of a good state of health, before beginning any prolonged near work for the eyes. The true prophylaxis of myopia for such weak-bodied children is life in the open air, in the country, where the recovery of a fair measure of good health will be accompanied by an increase in the firmness of the ocular tissues. Surrounded by such salutary influences, the child will be the gainer in the end for temporary suspension of the education; for with return to health the eyes can support more prolonged efforts and the progress of learning will be more rapid.

Our second indication is to surround the myope with the best possible conditions for work at close distance. The questions of illumination, of school furniture, of the distribution of the hours of work, and of the type of books,

arise here; but as these problems concern equally hypermetropes, it will be necessary to discuss them separately.

All these conditions fulfilled, there yet remains the very important question of glasses for the correction of the refractive error, and, by this correction, the avoidance of future increase of near-sightedness and the prevention of the complications to which the myopic eye is exposed. Upon the proper selection of concave glasses so much depends that a specialist should be called if it is possible to have your patient consult one. But there are places where it is almost impossible to reach such an oculist, and for physicians so situated the following rules are appended: If the myopia is of small degree and the accommodation normal, the patient may be allowed the constant use of the concave glass that corrects the error of refraction (Fig. 3). In those

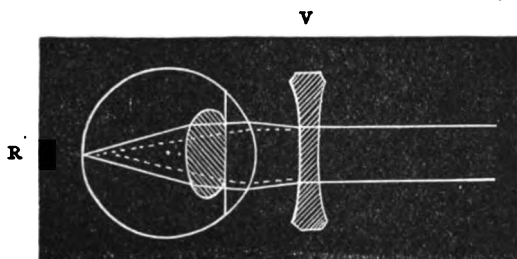


Fig. 3.—CORRECTION OF MYOPIA BY A CONCAVE GLASS.—V., concave glass. R., Retina, where corrected focus is found.

affected by myopia of high degree, where there is no impairment of vision, and where there is no alteration in the fundus of the eye, a concave glass is prescribed for distance and a weaker glass for reading. The reading-glass should be of a strength admitting of work at 25 centimetres without the exercise of too great an amount of accommodation.

If the visual acuity is diminished there is imminent danger before the child. The future of the eyes is doubtful, and the family physician is culpable if he does not advise consultation with a specialist without loss of time.

*(To be continued.)*

## A PLEA FOR THE INNOCENT OVARY.\*

BY

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In the practice of abdominal surgery the most difficult thing is not the manual, but what might be called the mental portion of the work, *id est*, the settlement of questions that are opened up by the operation itself. Among these questions none is perhaps more serious and important than to determine whether, after having removed one ovary and its corresponding tube, we should also take away its fellow before closing the abdomen. When the Battey-Tait operation was coming into vogue the practice was to limit it to the removal of one ovary. The exception to this rule was when both of them were evidently involved in a common disease, or when the ovaries were taken for the relief of an intractable menorrhagia, with or without fibroids.

At present, however, most of those who practice the removal of these appendages prefer to take them both away in every case, the theory being that if one of them has been diseased and is removed, the other is almost certain to become so if it is allowed to remain with the pelvis. It is claimed that the sympathy between the two ovaries is as intimate as that which exists between the two eyes; but surely the oculist who finds it necessary to extirpate the diseased eye-ball would not argue that the opposite globe should also be removed lest it might become involved if left behind. Indeed his practice is to take away the diseased organ as soon as possible, in order to save the other one.

My own experience has led me to conclude that in tubo-

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\* Read before the Clinical Society of the Hahnemann Hospital of Chicago.

ovariotomy the rule must vary in different cases, and that the most careful judgment is requisite to settle this question properly and to the best interests of all concerned. That there are cases in which it would be wrong to make the double operation there can, I think, be no doubt; and conversely it is none the less true that the clinical and anatomical conditions may, and usually do, require that both ovaries shall be removed at the same time.

If the trouble is due to a displaced or a strangulated ovary, with or without serious adhesions, it is not always necessary to take them both away, whether by the abdominal or the vaginal method. The same is true if the lesion that calls for extirpation can be traced to the direct traumatism of either ovary, as from a kick or a blow in the inguinal region. Most cases of ovarian epilepsy can be traced to an accident of this kind, and are as justly entitled to the appellation "traumatic" as are those cases of cerebral epilepsy following an injury which in these latter days are cured by trephining. And while a few of these cases of strictly menstrual epilepsy are cured by limitation when both ovaries have been removed, it is a serious question whether the operation has not failed in many others because the sound ovary has been unnecessarily sacrificed and the catamenial function inadvertently suppressed.

Before making an ovario-salpingotomy for the cure of this form of epilepsy, my habit is to make the most diligent inquiry concerning the date and cause of the first attack, the location of the injury, the time of the month at which it occurred, the modification of the menstrual experience since that time, whether the paroxysms always recur at the period, and how they are affected by the flow. Then, when the diseased tube and ovary have been cut away, if the other ovary is apparently sound, and the tube is not distended or abnormal in any way, more especially if the patient is a young married or marriageable woman, and if

there are no signs of an old and recurrent pelvic peritonitis, they are left *in situ*, and usually with a good result.

CASE I.—Some years ago a girl of twenty-two was sent to my department of the hospital from Michigan for treatment for an inveterate hystero-epilepsy to which she had been subject since having had a serious fall soon after the menses were first established. The epileptiform symptoms were so pronounced, and the fits had become so frequent, that, before doing anything in an operative way, my colleague Prof. Fellows was asked to see the case with me. He decided that until the damaged ovary was removed, it would be of no use to treat her medically for the relief of the nervous symptoms, and advised its extirpation. The left ovary and tube were accordingly taken away, and the right one was left. She made a good recovery from the operation and returned home. The fits recurred, but with a gradually decreasing severity. The menses were normal, however, and the remedies which Dr. F. continued to send her for a few months finally disposed of the paroxysms altogether. In a little while her marriage engagement, which had been broken off because of her ill health, was renewed, and now she is the happy mother of a healthy child.

CASE II.—Miss T., æt. thirty, single, began to menstruate at fourteen. She grew rapidly, was very active, but was well, excepting that she had an attack of circumscribed peritonitis which resulted from taking cold, and which was followed by effusion. This trouble soon yielded to apis and other appropriate remedies, and her health was completely restored. Menstruation was regular and almost painless. At seventeen, while descending the steps of the High School building, she slipped and fell in such a way as to cause the most intense pain and suffering in the right iliac region. This accident sent her to bed, and she was very ill, her pains merging into a terrible attack of dysmenorrhœa, with spasms and general convulsions.

At the time of her admission to the hospital as my pri-



vate patient her mother said that, in the fourteen years that had elapsed since the fall, she had never failed to have these convulsions with the recurrence of the menses; nor, excepting a very few instances, when they were induced by over-fatigue or excitement, had she ever had any spasmodic symptoms at any other time. These menstrual fits were epileptiform, were always accompanied by foaming at the mouth, unconsciousness, and prolonged sleep at the close of the attack. They usually came at night, or in the early morning, and of late were much more severe and protracted. Although she had forgotten the fall, and had never regarded it as the exciting cause of her troubles, all the pain and suffering at the month was referred to the seat of the injury.

A careful laparotomy exposed the offending ovary and tube, both of which were badly damaged, and both of which were excised. The corresponding organs were, however, healthy, and were allowed to remain. There was nothing wrong with the peritoneum. She got well promptly, and, for the first time since the mishap, soon menstruated as she had done originally, without pain or any nervous accident or incident, save that an hour or two before the flow began her temperature suddenly mounted to  $105^{\circ}$ .

It is a great pleasure to have restored this young woman to health, and not, through an excess of operative zeal, to have entailed upon her a life of generative incapacity, for now she is happy in anticipation of her approaching marriage. Two months have elapsed, and she has had no recurrence of the convulsions, and only one slight whirl, with a few nervous symptoms that were threatening. Her family have been told that they cannot reasonably expect her to be exempt from these visitations unless she is subjected to a strict quarantine at the month, and to the influences of quiet home life, with proper medication between times, and that even then the old habit may recur occasionally.

These and other cases of a similar kind have convinced me that the current opinion which holds that hystero-epilepsy is not amenable to surgical treatment, and is never benefited by the Battey-Tait operation, is wrong and misleading. When it is really a genital neurosis, and especially if it is of traumatic origin, with menstrual exacerbations that are distinct and consequent, I think we may reasonably promise a good measure of relief, and perhaps a radical cure in most cases. Something, of course, depends upon the duration of the disease, heredity, and a host of possible complications, and very much also upon our ability to keep the menstrual life and the generative function intact *by leaving the last and the innocent ovary where it belongs*. In some of these cases, too, the very best effects may be derived from the use of appropriate remedies *after the thorn in the flesh has been removed*.

There is another class of one-sided ovarian disease in which the double operation is neither necessary nor advisable. In chaste young women who are unmarried, exemption from the consequences of sexual wear and worry, of specific tubal disease and of the post-puerperal possibilities, relieves them in a great measure from the liability to a simultaneous involvement of the uterine appendages, or to an extension of the disease from one ovary to the other. Surely this fact deserves to be remembered when we come to the extirpation of the diseased parts, and it ought to protect these patients from being needlessly maimed.

There is plenty of evidence to show that the sexual instinct and capacity may survive the removal of both the ovaries, and that it may even be more natural without them, if they were diseased; but no one has claimed that the generative function is not abolished when a woman is robbed of her last remaining, healthy ovary. We should consider these clinico-moral questions more carefully and conscientiously, or somebody will start a society for the protection of these innocent little organs, as they are re-

lated not only to the preservation of the species, but to the happiness of mankind.

CASE III.—*Hypertrophic cirrhosis of the left ovary; tubo-ovariotomy, with a prompt and perfect recovery.* Miss —, twenty-five years of age, had been an invalid and almost constantly under treatment for five years. Her illness dated from what was said to be metritis, and the first attack kept her in bed for eleven weeks. In the beginning she menstruated copiously, but with an intermittent discharge. For two years past the monthly suffering has very much increased, at which time, and especially during the flow, she always has a severe pain in the left ovarian region. This persistent pain is always of a burning character and is often accompanied by throbbing. The nervous system is badly broken up, the appetite is very capricious, the bowels are obstinately constipated, she is very anæmic, and the feet are sometimes puffy and swollen. For three months past the menses have not appeared. Her enfeebled health has excited the sympathy of her family and friends.

This was the patient's condition when she was placed in the care of our clever friend, Dr. O. W. Carlson, of Milwaukee, who at once detected an enlargement of the left ovary, and sent her to me to see if that organ had not better be removed. The result was that we made the operation in St. Mary's Hospital, Milwaukee, with the assistance of Dr. Carlson and Dr. Belle Reynolds, July 20, 1889. The left ovary was of irregular form, cirrhotic, as large as a goose-egg and slightly adherent, while the outer extremity of the tube was also thickened and enlarged. The right ovary and oviduct were free and normal in every respect. There were no signs of peritonitis, uterine hyperplasia, or of any other abnormality within the pelvis. The sound ovary was left, and the wound was closed with the usual precautions and in the usual way. She had the best of nursing and care and made a prompt and perfect recovery. All of her old symptoms have now disappeared, and she is absolutely well again.

That the future of this operation is full of promise for

suitable cases there can be little doubt. It has been abused because it has been misapplied, because too much has been claimed for it as a curative source, and because, under the lead of certain distinguished operators, it has been thought necessary always to take both the ovaries, instead of practicing the more conservative method of leaving one in exceptional cases. It is because the cases in which it is possible to save one ovary are comparatively rare that this question merits our careful study. If there is only one case in fifty in which an ovary that is healthy in all its relations can be saved, we ought to give the patient the benefit of a sensible and skillful discrimination in its favor. And even if now and then we leave one behind that should have come out, it will be easier to repeat the operation and under proper conditions to remove it, than it would be to replace it.

There are those whose ultra-conservatism leads them to disprove of the extirpation of the uterine appendages in all cases in which no organic change of structure can be found and demonstrated; but this is not a safe and satisfactory guide, for the clinical history of ovulation is sometimes more pressing and important than any anatomical considerations whatever.

The study of cases in which it is imperatively required to take both the ovaries and their corresponding tubes at the same operation, which indeed is the rule and not the exception, must be deferred.

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### RETAINED PLACENTA.

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BY

H. USSHER, M.B.,  
WANDSWORTH, ENGLAND.

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In my last communication Nit. 3x. should have been printed Nux 3x. One thing forcibly arrests my attention, that out of many labors few have uncommon features. All

men do not use patience, or *pulsatilla*. One woman I attended some years back had an everted uterus, but I learned that in the labor preceding this one, her medical caretaker, being short of time and temper, chucked the cord so forcibly that a turning inside out was the result; and after the second labor—a long time before—nature was quieted after this outrage.

If the placenta does not come away in half an hour, my practice has been to give *puls.* 3x, a drop or two on the tongue, and this rarely fails to have the desired effect. I prefer it to *ergot*; and should the delay be longer it will, aided by gentle kneading, succeed. When pains are feeble and need help, my remedy is *cautophyllum* ʒ gtt. xv. in half-tumbler of water, dessert-spoonful doses every ten minutes. No medicine I know of gives better pains, almost as soon as swallowed, and retained placenta is rarely a trouble.

I don't think we bear in mind as we should the soothing power of opium, so well and so long established; the *liq. morph. hydroch. B.P.* is a pleasanter dose than *laudanum*. A lady was out of her count, as we thought, but she was very positive that she had gone ten months; the absence of her husband made this certain to her. When the labor took place we counted back and found she was right—right on that point, but wrong every other way. She used to turn momentarily blind and deaf, said her baby cried and annoyed her; the urine was albuminous. Through her pregnancy she was depressed and an invalid, but mental and body weakness gave way under *lilium tigr.* ix. It routed the gloom that was over her. A consultation revealed the fact that the head was abnormally large. When labor came on it proved to be a breech presentation. All up to the shoulders was born for hours. I was with her the whole night, and a local practitioner with a large obstetrical experience failed to make an advance, either singly or with my added force. There was nothing for it but perforation, and at an

early hour in the morning we called a London doctor, who tried to do what we did, and made no more progress. At last he perforated and delivered the child. Then the cause was evident—a hydrocephalous head with the bones of the head pressed outward, so that they acted as a wedge against every pull of ours, and no force could have succeeded. She bore all the terrible ordeal magnificently, but when death hovered over her, patience and careful dealing with symptoms brought her through; as good a recovery as ever took place.

My hands were untied; though her brother-in-law was an allopath and hates homœopathy, her friends held on to me, and my success was rewarded.

When you have a case of this kind, severe beyond usual, don't be afraid of bell. 9, even five drops for a dose, and if necessary, liq. morph. hydrochlor. B. P. What would we have done without these and arnica?

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## UTERINE HÆMORRHAGE: A CASE.

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BY

RUFUS CHOATE, M.D.,

ROCKVILLE, MD.

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Mrs. Blank, a compactly built woman, full of energy, of cultured mind, and opposed in every way to a state of passivity, presented the most obstinate and dangerous passive hæmorrhage it has been my lot to treat. The history is the repetition of thousands of maltreated cases. In her girlhood a doctor of medicine discovered ulcers on the mouth of the womb, and in accordance with the barbarous palliative treatment of the old school, repeatedly, even at times daily, applied a strong solution of nitrate of silver. Whether he cured the ulcers or not, we are certain that he

had no regard for, nor thought of, the health and life of his patient. Miss Blank pulled along through the influence of a strong will, married, and had a womb whose muscular power had been destroyed. The first child miscarried at the sixth week; the second died in birth; the third was removed by forceps, breathed, and passed heavenward. The miscarriage was followed by falling of the womb. The applications of the criminally palliative nitrate of silver was during the lady's seventeenth and eighteenth years; the marriage at her twenty-fifth year; the miscarriage at twenty-six; the first birth at thirty-three, and the second at thirty-four. She is now forty years of age.

Nov. 27, without apparent cause, a tinge of blood gave reason to suppose the menses, which were delayed one week, had now begun. There was no pain, nor has there been any throughout the entire case. Nov. 29, the slight flow became profuse, and on the 30th quite free. Dec. 2 and 3, it ceased somewhat; after which, to the date of its cessation, Dec. 24, when through the action of the medicine the cause was removed, the flow kept up without the slightest stopping. From the 3d to the 24th of December, a sponge saturated with blood was removed from the vagina on an average of eight times in each twenty-four hours.

In the beginning the patient supposed the flow was due to natural causes, and failed till Dec. 9 to call for professional assistance. When I was summoned there were no guiding symptoms; no pain, no nausea, no faintness, no chilliness, no anxiety—nothing more than a continuous, passive, painless flow. Daily expecting the medicine prescribed to accomplish the work, uterine examination was postponed till Dec. 20, when not having done the least good through the administration of carefully selected drugs the examination was made with the following results: An ulcerated internal os, the ulcer extending far into the uterus. The walls of uterus were infiltrated and hard as though a

myo-fibroic tumor would soon develop, and the lower portion of the uterus was greatly swollen and low. The womb appeared white and as if deprived of blood. The internal os was greatly distended. The discharge was from the ulcerated surface. I applied a tampon of tincture persulphate of iron, and continued, with increasing anxiety, the internal treatment. The remedy was palliative, and the improvement temporary. The local application of iron was repeated till the 22d, when it was discarded as of no avail. On Monday, Dec. 23, I called the assistance of Dr. A. A. Roth, one of the ablest homœopathists of our State, who confirmed in every particular my diagnosis, only advising that the selected drug be used in low potency. I had been using the 200th, and failing, found no reason for objecting to the advice of my colleague. Hamamelis x, 10 drops in 10 teaspoonfuls of water, teaspoonful every hour, was ordered. For eight hours this was administered without the least sign of improvement, or cessation of the discharge. Dr. R. had returned to his home, and the case was fast growing critical. At near midnight of Dec. 23, I roused the Blank household and informed my now uneasy patient and the distressed husband that I possessed the means of recovery. One powder, dry on tongue, of argenti nitras 200th was given, with orders to repeat this next morning. Tuesday, the morning of Dec. 24, the flow continued the same in quantity, but the patient had changed greatly in appearance. The dark-yellow had changed to a clearer and more natural complexion. She said she felt each dose of the medicine go all through her, and so evidently as to frighten her, and had seriously considered the danger of taking the second dose of a medicine that could produce such sensations. I was fully satisfied and positive that the drug was doing grand work, and repeated it for Tuesday night and Wednesday morning.

On Christmas morning happy greetings welcomed me. The flow had ceased. That is to say, the red blood had



ceased to flow, but the sponge was repeatedly saturated with water and serum. The patient was surprised at this, and thought possibly, though it was improbable, that the urine had passed into the sponge. From this I suspect that argenti nitras first affects the red blood. Since Christmas day, once, on Dec. 27, there was a passage of a tablespoonful of clear blood, and then I prescribed another, and the last dose, of arg. nitr. The patient continued doing well, with rapid subsidence of the uterus and the disappearance of all bad symptoms.

## LACERATION OF THE CERVIX UTERI.

BY THE LATE

F. S. FULTON, M.D.

(Continued from page 158.)

Generally no artery forceps are necessary. If the circular artery be cut it can be best secured by passing a thread of catgut or whale tendon beneath it and ligating it through the tissue. If a tenaculum is not desired, the tissues as they are dissected up must be caught by a pair of tissue forceps, which should be toothed and possess a slide

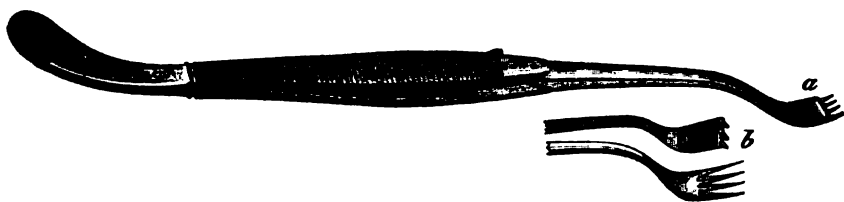


Fig. 22.—Tissue Forceps.

that the grasp may be firm. Many forceps have been devised for this purpose, and every operator has his own particular favorite. One of the latest of these has been devised by Dr. Geo. Cowan of Danville, Ky., and is designed to first

transfix the part to be seized and then to clamp it, in this way preventing the constant slipping which is the trouble with most others. As we have never tried it we cannot speak of its value from experience.

The needles to be used will vary with the operator. The



Fig. 23.—Emmet's Needles.

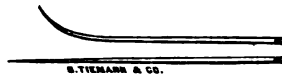


Fig. 24.—Sims's Needles.

majority of surgeons use either Emmet's or Sims's. For practical use we prefer Emmet's latest needles, which are slightly curved at the point, and instead of being round pointed as were his first ones, have three rather dull cutting edges which greatly facilitate their passage through the dense cervical tissue.

Dr. Helmuth prefers and usually uses the large heavy

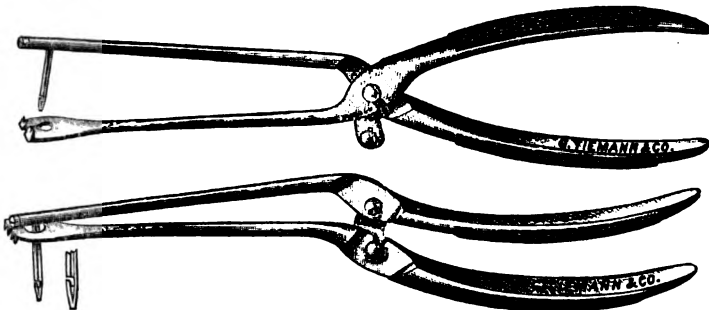


Fig. 25.—Van de Warker's Needles for Lacerated Cervix.

Helmuth needle, for the sake of greater rapidity and ease of placing the sutures. Dr. Van de Warker of Syracuse has devised a needle especially designed to overcome the difficulty of passing small or large needles through a very tough cervix retracted, as it sometimes is, high up in the pelvis.

These will be found useful at times, but under most cir-

cumstances no device will be found equal to the ordinary needle placed at any angle desired in a serviceable pair of needle-holders. With these either a counterpressure hook, as figured below, or Emmet's blunt hook must be used to

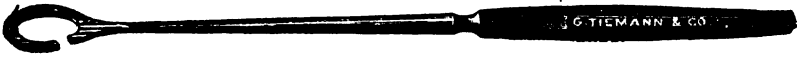


Fig. 26.—Counter-pressure Hook.

exert pressure against the cervix while the needle is being forced through.

If in the operation wire is to be used, a shield or wire



Fig. 27.—Emmet's Counter-pressure Hook.

adjuster and wire twister will be needed. Emmet's instruments are most excellent for this purpose.

Any heavy pair of scissors will answer as wire scissors. A uterine sound will also be needed, and half a dozen sponge



Fig. 28.—Emmet's Wire Twisting Forceps.

holders and small sponges. These will comprise the necessary instruments. According to the preference of the operator, will be needed silver wire, silk, whale tendon or catgut. Each of these materials have their special advocates.



Fig. 29.—Sims's Wire Adjuster.

The greater number of operators prefer wire. Dr. Skene uses silk and claims excellent results. Dr. Helmuth and some other surgeons use almost exclusively whale tendon, which is a Japanese article and manufactured by teasing out into small threads the actual tendon of the whale. These threads are then twisted and spun together as ordinary silk. It was discovered by Dr. T. Ichiguro, chief sur-

geon of the Imperial Japanese army, who first introduced it in 1877. The advantages of it are: first, that it does not have to be removed, as being an animal substance it becomes absorbed in between four and seven days according to the strain and location; the sixth or seventh day will find nearly all those portions which are subjected to any strain softened and absorbed. Second, that it allows of a certain amount of giving as the tissues swell, and thus prevents cutting through. It apparently does not absorb quite so quickly as catgut. I believe from my experience and that of others that silver wire possesses great advantages over any of the others. Properly prepared silk would probably do well also. Dr. Sims, I believe, first introduced silver wire to the notice of the profession. Since then it has rapidly grown in favor, and is now used almost exclusively by the most prominent gynecologists of the country, among whom Emmet, Mundé, Hunter, Pallen stand foremost. The advantages which it possesses over all others are, that it is clean and entirely aseptic; that, if necessary it can be left *in situ* for two months or more; that the rigidity of the wire gives proper support to the tissues while uniting, and that, being approximated by twisting, the tension of the suture can be accurately adapted to the needs of the coapted parts. Further, a great advantage which I believe it possesses over whale tendon or catgut lies in the fact that both of the latter are absorbed in from four to seven days which does not allow time enough for the parts to unite except under the most favorable circumstances. I have never seen a cervix in which catgut or whale tendon were used in which in some place the stitches had not given way and allowed the parts to gape to a greater or less extent. In some cases, despite every effort, or from some fault of the operator, sloughing will ensue. If that occurs with the whale tendon or catgut, it makes the operation necessarily a total failure, as the suture will have absorbed and can give no support to the part; or in certain cases healing is

delayed, until several days after the absorption of the sutures, in which case also, for the above reason, failure must result. But if wire is used in either case, by tightening the sutures and irritating the surface in the first place, or by allowing the sutures to remain for a week longer, most frequently union will occur.

Numerous cases are recorded where this has been illustrated. I have had a similar experience in the case of a lady who had previously been operated upon, whale tendon being used, with a result of union on one side and total failure on the other. In the second operation silver wire was used but still one lip sloughed. In a state of desperation I irritated the surfaces, and allowed the wires to remain. An examination a week later showed union along the border of the cervical canal and in a great degree of the cleft. The result after a few months was entirely satisfactory as regards both the cervical lesion and reflex neuroses. I examined the patient about eighteen months after the operation, and found that the mucous membrane over the cervix was perfectly normal; there was a slight nick in the side which had sloughed, but the tissues had adhered along the line which was to and did for the cervical canal, preventing any erosion and restoring the cervix to the normal size and contour, excepting the slight nick. It should be stated also that to a subsequent operation for urethrocele which I performed must be attributed considerable credit for her improved condition. The only objection to wire is the necessity for its subsequent removal. But this is neither difficult nor painful in ordinary cases, and the slight inconvenience should not deter the practitioner from giving the patient the benefit of the best means at his disposal.

Dr. Skene uses braided silk, prepared by soaking it for five or six hours in melted wax, to which has been added carbolic and salicylic acid. The thread is then taken and drawn through a piece of cardboard to remove all the superabundant wax. Dr. Skene prefers this to silver wire.

**METHOD OF PERFORMING THE OPERATION.**—On the night preceding the day of operating, the patient is given a mild cathartic, compound liquorice powder from one to four teaspoonfuls, or Hunyadi water one-third of an ordinary tumblerful, or citrate of magnesia one-half to one bottleful; or, in some badly constipated individuals, a compound cathartic pill may be needed.

Having insured a free movement of the bowels in the morning, an enema is also to be given about three or four hours previous to the operation, in order to free the rectum and colon from any remaining fecal matter. About one-half hour before the operation a heavy vaginal douche is to be given as hot as can be borne by the patient, both for its cleansing effect and its astringent action on the cervical blood-vessels. Hæmorrhage at the operation can be reduced to a minimum by means of the abundant use of hot water previously. As in all operations where ether is to be given, only a very light breakfast should be taken. If the afternoon is the time selected a cup of broth, or beef-tea, or milk, can be taken at eleven o'clock. The instruments should be in carbolized water, 1 to 40; the hands of the operator and attendants should be carefully washed with soap in a carbolized solution. No one should be allowed to touch the parts whose hands are not thoroughly aseptic, as serious failures have resulted in which no reason could be assigned other than meddlesome interference on the part of those who failed to appreciate the importance of anti-septic precautions.

Some system of irrigation should be at hand by which a douche of hydrarg. bich., 1 to 2000, can be thrown into the vagina just before and also at the completion of the operation. The most convenient method is the use of large two-gallon irrigation bottles to which is attached rubber tubing with glass nozzles and a spring catch. A short gynæcological table, four feet by two and a half, and two and a half

high, is the most convenient. The table should be upon heavy casters to allow of its free movements.

The instruments are placed at the left of the operator near the lower end of the operating table; the table for sponges at the right, a chair for the operator at the foot of the operating table.

When everything is in readiness the patient is introduced, placed upon her back on the table, and anæsthetized. When this is accomplished she is turned over on her left side in Sims's position, well on her chest, the pillow at her head removed to facilitate respiration, and her limbs well drawn up, the right knee being higher than the left, and towels placed around her buttocks and a rubber elastic under them. An assistant attends to the ether and nothing else, another stands at the back of the patient to hold the speculum and retract the labia or buttock, another at the operator's right to manipulate the sponges and keep the parts free from blood. If assistants are plentiful it is well to have one, a nurse, keep the sponges clean and hand them to a physician who will keep the parts free from blood. The speculum, warmed and well oiled with vaseline, is introduced and given to the nurse or assistant to hold. The douche of merc. bich. is then given, and cervix seized and drawn carefully downward toward the vulval orifice, great care being exercised not to exert traction where there is any resistance arising from old bands which have been deposited by some preceding cellulitis. The cervix in ordinary cases can be drawn to within an inch of, and sometimes entirely outside, the vulva without danger. It is not safe, however, to practice the latter usually as there is great danger of exciting peritonitis or cellulitis, and ordinarily an operation can be performed with but little discomfort with the cervix from an inch to two and a half within the vagina. It should always be the rule to avoid all unnecessary traction. The cervix can either be held steadily *in situ* by a double tenaculum or by passing a double thread through

the anterior lip and tying it, by which means the cervix can be manipulated to suit the convenience of the operator. The most convenient method, and the one which I employ, is to seize the posterior lip with Skene's double tenaculum, Fig 21.

The catch prevents it unhooking, while the small peg in one blade and the construction of the instrument prevents any compression of the tissues. The bend in the instrument is also of advantage, as are its strength and firmness. The insertion of a thread in this lip is sometimes a matter of some difficulty, as the uterus is sometimes high up and unmanageable. The tenaculum saves time and patience.

Whether the laceration be anterior, posterior, unilateral, or bilateral the operation is practically the same, excepting that in the bilateral the denudation must be double what is necessary in the others. For the stellate and internal laceration a different proceeding must be adopted; of that we will speak later. Of the others a description of the bilateral will suffice, as it includes the remaining. Having the cervix within easy adjusting distances, the everted lips of the cervix are brought together by means of tenacula, placed in either lip, in order to determine the amount of tissue to be removed and to mark out the area of denudation. Having determined this and also where the cervical canal must be located, the mucous membrane is hooked up upon a tenaculum or grasped with forceps, and the work of cutting commenced. In a bilateral laceration it is well to operate the lower cleft first, in order to avoid the constant running of blood over the surface upon which you are cutting which will result if the upper surface is denuded first. The mucous membrane to be left for the cervical canal is mapped out with the eye, and with the curved scissors the mucous membrane to the left of that is then cut away until the entire cleft is bare, care being taken to make a clean and complete removal in the angle of the laceration. The denudation must be carried well out toward the vaginal junction to



prevent any puckering of the tissue. The amount to be removed must be governed by the extent of the laceration and the consequent size of the flaps to be coapted. Fig. 30 represents the area of denudation and the strip left for the cervical canal.

If the cervix and denuded area could be transformed into a flat surface it would be seen that a triangular piece with its base impinging upon the cervical canal had been removed. Fig. 31 well represents this. If there is no cicatricial tissue in the angle of the cleft this is a comparatively easy matter, but if as is usually the case a large plug of

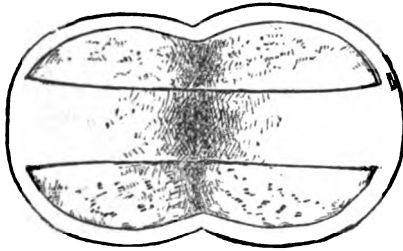


Fig. 30.

scar tissue has been deposited at the angle of laceration, its removal is attended with considerable difficulty. The impression and sound arising from the cutting of this hardened tissue is quite distinct from that caused by the division of healthy cervical tissue. An impression of additional resistance is conveyed to the operator's fingers; while the sound is harsh and grating like that produced when toughened tendon is divided by scissors. Oftentimes the eye can detect the shiny, gristly appearance and the absence of hæmorrhage from the incised surface. The best guide to its presence is, however, found in the *tactus eruditus*. With the finger and nail the dissimilarity between the tissues can be easily detected. The healthy is soft and yielding, not nodular and projecting, while the cicatrix is hard, lumpy, conveying to the finger a sense of resistance not found in

the normal cervical tissue; this entire amount must be removed. The depth of the incision is not a matter of great moment unless, as is very unusual, it extends beyond the os internum. If any portion of it is left the easy and natural coaptation of the lips is hindered; the probability of union by first intention is seriously diminished, as cicatricial tissue has but little tendency to unite; and what is of the greatest importance, in the majority of cases the reflex menses, such as headache, backache, vesical trouble, neuralgia, etc., will probably not be materially benefited, as

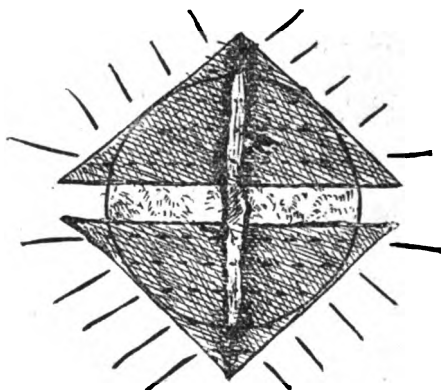


Fig 31.

these disturbances depend very largely upon the pressure exerted upon the sensitive cervical nerves by this cicatricial plug. Piece after piece must be caught up by the tenaculum or forceps and cut away until the finger fails to detect any remaining. In this, sometimes, deep dissection there is danger of incising the circular artery of the cervix. Unless this accident occurs the resulting hæmorrhage is of little moment. If the circular is cut the bleeding can easily be controlled by the artery forceps and ligature, which is a rather difficult process owing to the difficulty of properly securing the knot at that depth without including the blade of the forceps, or by passing a small needle threaded with a

piece of fine catgut through the flap just below the artery. This can be easily tied and cut off short, stopping the hæmorrhage and not in the least interfering with subsequent union.

The flaps having thus been symmetrically denuded and found to coapt easily, the operator can pass to the other side. If the flaps do not approximate readily it is evidence of still more cicatricial tissue at the angle, which must be removed. In going to the opposite side and commencing the denudation, the operator must very carefully mark out the portion which is ultimately to form the cervical canal. Over this portion on both sides of the os the mucous membrane must not be removed except in certain cases which are mentioned below. Symmetrical strips of mucous membrane should be left on either side of the cervical canal between the triangular surfaces which are denuded. These strips should be wider at their outer extremity which is to form the os externum than at the inner, in order to give sufficient size to the uterine canal and to prevent either dysmenorrhœa or sterility resulting from partial stenosis of the canal. Having been careful to leave sufficient mucous membrane, the second triangle is to be denuded, care being taken, as before, to remove the cicatricial tissue and to make the flaps symmetrical.

At times the anterior lip will be found greatly hypertrophied so as to render it difficult to make symmetrical flaps. It was for this condition that Goodall was accustomed to remove a V-shaped piece from the lip as a measure preparatory to trachelorrhaphy.

For this same condition Dr. Emmet has employed a different device. He denudes the posterior lip upon the vaginal junction down as much as there is hypertrophy of the anterior lip. He then adjusts the flaps, thus reducing the hypertrophy by drawing the anterior lip down and uniting it to the lengthened denudation on the posterior lip. Another method of reducing this hypertrophy is by denud--

ing the entire anterior lip, and cutting away all the excess of tissue until it is of the same size as the posterior and the denuded surfaces are symmetrical. The mucous membrane which is left upon the posterior lip insures the potency of the canal. By this method there would be greater danger from contraction of the granulating surface on the anterior lip.

*(To be continued.)*

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### COMMONPLACE MIDWIFERY.

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BY

GEORGE WILLIAM WINTERBURN, M.D.,  
NEW YORK.

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*(Continued from page 146.)*

POST-PARTUM HÆMORRHAGE.—Real post-partum hæmorrhage, that is, flooding coming on after the third stage is completed, whether this happens after half an hour, or after two or three days, is a most serious thing, and there is no emergency in midwifery which leaves less time for reflection. In one case occurring suddenly nearly an hour after the delivery of the placenta, and when I had my overcoat and hat on ready to leave the house, I stopped by passing my hand up into the uterus, and tickling the inner parieties with my fingers; the uterus contracted down on my hand, and the flow ceased. I never saw a woman lose so much blood in a minute or two; it was just such a hæmorrhage as one would see from a severed jugular. I had heard of rivers of blood; I saw one that night.

The value of the faradic current in these emergencies is undoubted, and I always leave a two-cell battery, in running order, at the side of my desk so as to send for it if I apprehend any danger of hæmorrhage. I also, during the first stage of labor, secure a nice juicy lemon, so as to have it handy in case extensive bleeding occurs in the third stage,

or later. Half a lemon carried up into proximity with the bleeding surface, and the juice squeezed out against it, will put an end to the bleeding. Ice is good, but not as good, nor as easy to handle, as a piece of lemon, and adds to the already existing shock. I use ice, and ice-water, to effect the expulsion of a retained placenta, but rarely in hæmorrhage from an empty uterus.

I very much doubt if the ergot treatment of post-partum hæmorrhage is any considerable advance on the brandy and opium of years ago, especially when this was fortified with small doses of capsicum. In fact I have ceased to carry ergot, and do not remember to have used it for three or more years, except as it forms part of the formulary of Hayden's styptic, in which combination it ceases to be ergot, in my opinion.

The pulse-rate is a fair index of the safety of the patient. If after delivery it remains above one hundred beats a minute flooding is imminent. Now is the time to show how good a homœopathist you are.

Even in cases which have been in every particular normal, it is my custom to leave a small vial of Hayden's styptic with the nurse; with directions how to use it, if hæmorrhage sets in. Only twice, as far as I now recollect, has this precaution been of service, and the same vial has done duty in many successive cases; but the mental relief that one feels in thus providing for a contingency well repays the small trouble of it.

ACCIDENTAL FÆTAL DEATHS.—Of these I have had two at term, and they were both interesting enough to deserve relating. I will take the last case first. The woman was a well-developed and pleasant-faced blonde; such a one as you would expect to be a good breeder. Her mother was a monthly nurse, and had been known to me for some years previous to the time of which I speak. She was an unusually intelligent woman, and the daughter was well educated for one in her station. She was married to a man some

years older than herself, a painter by trade and a superior workman, but who spent his surplus wages on horses and horse racing, and was generally fast. Him I never saw, but subsequent events led me to suspect that he had a syphilitic experience before marriage. However this might be, the wife was bonny and attractive; such men are apt to get the nicest wives. The mother came to engage me, and I subsequently called on the daughter. Nothing was said about any previous children, and I imbibed the notion that this was a first pregnancy. In fact the woman was so young, so bright, and fresh-looking that I jumped at a false conclusion without inquiry. Why under all the circumstances these two women should have failed to tell me of the two still-born children, both of whom died in the act of delivery, a certainly startling event when it occurs once, much more when it re-occurs, I cannot decide, except that it was blind fate. When I saw her for the first and only time before the confinement in which I attended her, she was so well that I could find no peg on which to hang a prescription; nevertheless I suggested that she should come to my office and report progress three or four weeks before the expected event. But I heard no more until one morning about half after three o'clock, when it was announced that "the waters had broke," and I was wanted in a hurry. I got there without unnecessary delay; but with the exception that the amniotic fluid had escaped, without any severe pains prior thereto, the case did not seem to betoken need for special haste. Digital examination showed the os high up and out of reach; the pains were very moderate, and the woman was able to take short naps in between; the interval from pain to pain being certainly twenty minutes or more. This state of things continued all through the morning, and as I had a number of cases to see, a lecture to deliver, and was due at the dispensary at two o'clock, I left the case in the hands of a student, with a messenger at his service, so that he could send for me instantly if needed. I returned to

the case at 5:30 o'clock, and found everything in the same state as when I left. The pains had been irregular, and not severe, and the prospect of speedy delivery was far from encouraging. I determined, however, to make a thorough examination under chloroform, and proceeded to do so at once; up to this time the child was known to be alive. I found the fœtus lying on its back with its head in the right iliac fossa, and both feet doubled up and level with the fœtal chest. After much trouble I succeeded in seizing the right foot by passing my hand up over the right shoulder, and making traction caused the body of the child to make a complete revolution. These manipulations brought on active pains, and the child was quickly in the world. There was a brief delay as the head reached the outlet, but not long enough to account for the catastrophe which ensued. The child was born asphyxiate, but as I anticipated that I was prepared for it. Without cutting the cord I submerged the body in a basin of cold water and then into one of hot (about 120° Fahr.), and endeavored to induce respiration; but there was no response. The child was a finely developed boy weighing in the neighborhood of eight pounds. Not to make too long a story of it, I worked over that child for more than two hours, administered tartar emetic 6, and subsequently camphora 9, succeeded by hot flannels and other means in keeping up external warmth, but at last gave out from sheer inability to go on. From first to last the child made not the slightest effort. When I sank down in utter exhaustion the old lady said: "I 'spected 'twould be that way; she always loses her children that way"; and then I learned of two similar experiences in previous years. I do not think it was the chloroform that did it, for this was used stintedly and cautiously, complete anæsthesia being maintained only for a few moments at a time, and although it was used continually for more than an hour, that is until the breech presented at the outlet, the child was not born in the limp condition which is seen often after continued

chloroform narcosis; and, as I was told, anæsthetics were not used in the previous cases, and as those likewise were healthy in appearance and well-developed, it is more than probable that the death of all three is to be accounted for along the same lines. The premature rupture of the membranes was possibly due to the pressure of the head cross-wise; the cord and placenta were normal in appearance; there was no event during pregnancy which could be cited as a probable cause for the death of the fœtus, which appeared to be purely accidental. This case taught me the advantage of the most rigorous inquiry into the history of the woman when engaging to take care of her during an approaching confinement. I thought I had been careful before, but this case showed plainly that confidence in one's opinions does not satisfactorily replace adequate knowledge of the facts.

The other case of accidental fœtal death was caused by a complicated position the like of which I have never seen described. On February 26, 1882, I was sent for to attend a case on Twenty-sixth Street, near Seventh Avenue; the patient was the wife of the pastry-cook in a leading hotel, and had already given birth to four children. She was a plump, jolly little body, and as the previous labors had been normal, as far as I could learn, no apprehension was felt of trouble to come. I arrived at the house about seven o'clock, and found the woman in great pain. Before I could make an examination the membranes broke, and a hand was thrust forth. This I replaced and shortly the other hand presented. This being likewise returned was followed by the first hand and a foot; both of which were spontaneously withdrawn one after the other. The child was in cross-position, prone, the head in the left iliac fossa. During all this time the pains had been very severe, but now they gradually died out, and a period of rest supervened lasting nearly three hours. I gave pulsatilla 6 during this period. Soon after noon the pains again became



severe, but short and unsatisfactory, and no progress being evident, foreseeing that assistance would be needed, I sent about four o'clock for Dr. Maria B. Hayden; and on her arrival proceeded at once to administer chloroform preparatory to manual delivery. I introduced my hand and seized the foot I found presenting. It came down several inches and then stuck fast. I made as much traction as I dared but it would not budge. Passing my hand along the leg up into the uterus I found the foetal head jammed in between its two thighs; the head and shoulders being bent forward and downward over the abdomen. Every effort to free the head failed, until at last putting the woman into the knee shoulder position it disengaged and podalic delivery took place. The woman made a good recovery, and I have since attended her in two normal labors.

PLACENTA PRÆVIA.—My experience in placenta prævia has been brief and unfortunate; though fortunate in its brevity. My one case was in December, 1881. The woman, 3-para, was middle-aged, and very stout, the pregnancy nearing the end of the eighth month. I had seen her once, about a month previously; at that time everything seemed moving along all right, though I found her taciturn and unwilling to say much about herself. About two o'clock, on the day of the case, the husband came to my house, just as I was starting for the dispensary. He stated that his wife was feeling very badly, and had lost a "lot of blood," which he seemed to think came from the bowels. I did not want the case, feeling sure there was no prospect of a fee, and scenting danger in the air. So I tried to induce him to go for some other physician, promising to look in after dispensary hours. I especially disliked at any time to break in on the dispensary service, when I had every day forty or more patients. But he would not be put off, so I made believe I did not want to go because he would not pay for the service. This he promised to do within half an hour,

would meet me at his own house, and started off ostensibly to get the money. I felt sure that his promises were fraudulent, as they proved, for he did not turn up until long after his wife was dead, and then, of course, without any money. Having foolishly made that excuse instead of sticking to my text of dispensary duty, I felt in honor bound to go, and went, sending to the dispensary for two of the students, Drs. House and Morehouse, who met me at the case about three o'clock. When I reached the house I found the woman had lost an immense quantity of blood—a half bucket full, the attendant said—and was flooding furiously. There were no pains, had been none, and none could be induced subsequently. The abdomen was very large, and the omentum enormous, making external manipulation ineffectual. The uterus was high, and the os pointed back into the hollow of the sacrum; I could not find it with my finger. I had carried a capacious syringe with me, and at once gave a thymolized hot douche, continuing it for some minutes, but producing no effect. We then gave teaspoonful doses of normal liquor ergotæ, every two or three minutes, plugging the vagina meanwhile with strips of muslin saturated with liquor ferri subsulphatis. But all to no purpose; the blood soaked down through the muslin as fast as we could apply it. Shortly the woman became delirious, then stupified, and at four o'clock was dead.

I am quite able to criticise the conduct of the case; and Sir James Simpson<sup>23</sup> has furnished the key to that criticism. He once said that to plug the vagina in placenta prævia was fool's practice! Doubtless the hand should have been introduced into the vagina, the os found, and the membranes ruptured, after the manner of Wielobycki. This would probably have precipitated the labor, brought the uterus down into the pelvis, and given the woman a chance

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<sup>23</sup> *Dublin Medical Journal*, vol. lxxxiii. page 194.

for her life; though the great loss of blood, and her general atonic condition presaged extremest danger under any treatment. Wielobycki, of Edinburgh, was the first, I believe, to demonstrate the utility of rupturing the membranes, by means of a catheter, and allowing the liquor amnii to drain away slowly. Dr. Reuben Ludlam, of Chicago, says: "This little operation, which any one could make, in case the woman was at term or not, would arrest the flow by plugging the cervix from within, and the contractions induced would put a sort of Esmarch's bandage on the organ so as to prevent an excessive flow of blood."<sup>24</sup> Prof. Guernsey, of Philadelphia, said in regard to perforating the membranes, in cases of placenta prævia, with a female catheter: "I have not heard of a single case of loss of the mother where this method of procedure has been followed, and the child is almost invariably saved. It must be remembered to evacuate the liquor amnii very slowly. Every accoucheur knows what bad effects follow the emptying of the uterus rapidly under such circumstances; the atony thereby produced is more to be dreaded than the former state. When the placenta is only partially over the os, even if it be but the edge of it, the same principle and practice holds good."<sup>25</sup> Wielobycki in twelve consecutive cases saved all the women, and nine of the children by this method.<sup>26</sup>

POST-PARTUM CHILL is usually provided against by having a couple of flat-irons hot, and an extra pair of blankets at hand. With a hot iron wrapped in newspaper at her feet, plenty of bed-clothes over her, and a nice warm drink to sip, even the most nervous woman will forget to shiver. Successful midwifery practice is largely made up of a series of forethoughts, by which all the minor discomforts and major emergencies are provided against.

... <sup>24</sup> *The Clinique*, Oct. 1889, page 364. <sup>25</sup> *Obstetrics*, page 85.

<sup>26</sup> *British Journal of Homœopathy*, vol. iv.

**RETENTION OF URINE.**—It is rarely that any trouble of this sort is experienced. Only once have I used the catheter, and then for the first three days only. Stramonium is a grand remedy, though nux vomica and arnica are sometimes needed. Probably the habit of giving a dose of arnica immediately after labor is complete has obviated much subsequent distress. The retention of urine in the new-born is always overcome by a dose of aconite, or the application of a sponge wrung out of hot water, on the pubes. I have never had a case of imperforate urethra.

**THE CHILD'S NAVEL.**—I understand it is customary to re-dress the stump of the cord daily. I never permit it to be touched after the first dressing, which consists in reducing it to as dry a state as possible, as already described, thoroughly saturating it with lard, and wrapping it in a bit of old linen, of which I generally have a supply with me. Good, pure lard is much better than vaseline, or any of the oils, and cotton waste, or cotton batting, are sure to be heating and irritating if greased. When the cord drops off on the fourth, or fifth, day, if the navel looks raw or unhealthy, a large raisin, such as is found on the top layer of the box, split, the seed removed, and the inner surface applied to the navel, and held in place by a strip of adhesive plaster, is all sufficient.

Sometimes a boy ruptures himself, at the navel, by over-much crying. A piece of cork, of proper size to fit into the umbilicus, stitched onto a flannel bandage, will retain the extruding part until adhesion takes place. If the rupture is a bad one, a small plaster made of marrow, out of a long (beef) bone, and the fluid extract of comfrey (*symphytum*) may be placed under the cork; or surgeon's plaster may be used to retain the comfrey plaster in position.

**THE AFTER-PAINS.**—Feeling the importance of absolute rest after labor, the subject of after-pains has had my most

earnest attention. As they have a physiological basis, we cannot altogether dispense with them, but with the exception of a few refractory cases—not more than a dozen in all—I have succeeded in controlling them so that they were not a source of real suffering, and in the cases where I failed, I believe it was ignorance on my part that prevented the administration of the proper remedy, rather than any poverty on the part of the materia medica. The fact is that either *rhys*, *arnica*, *bryonia*, or *sepia* are called for in nine out of ten cases; and in the tenth case we fail to make the nicer distinction required, and routinely give *arnica* when we ought to have given *ferrum*, or *belladonna*, or *nux vomica*, or, perhaps, *coffea*. I am satisfied that in many cases a nice warm meal is better than any medicine. Still, I have had several cases in which the pains were exhaustingly severe, and in which I was glad to turn to nitrite of *amyl*. This potent drug is a very efficient controller of after-pains; and used cautiously I see no reason to apprehend harm from it. A neat way of using it is to saturate a small piece of tissue paper with five or six drops, stuff this into a two-drachm vial, and request the patient to draw the cork and inhale the odor, when she feels the pain coming on. It acts with magical celerity.

LYING-IN DIET.—A generous diet is good for a lying-in woman. Judgment must be exercised not to overdo the matter, and not to tempt the appetite by too great variety; but suiting the bill of fare to the habits and condition of the patient, I am confident that a more nutritious dietary than is ordinarily permitted will be acceptable and beneficial to our patients. A poached egg on the first day, a few nice roast oysters on the second, and a bit of steak, or a chop, on the third day, in addition to the usual oatmeal porridge, warm milk, tea and toast, cambric tea, etc., are samples of what my patients get, and I have thanks and smiles in return. Milk is an important item, and while

most city-bred women have an idea that it does not agree with them, by beginning with a tablespoonful at a time and gradually increasing the amount, in a few days they will be able to drink a quart or more per day with relish. Effervescing drinks are useful and grateful to the patient, not only for the relief of thirst, but as favoring the action of the skin and kidneys. Mixed with milk they form a most welcome addition to the usual lying-in dietary. In order to avoid diluting the milk, I am accustomed to put a heaping teaspoonful of one of the granulated effervescent salts, Congress, Vichy, Seltzer, or Kissengen, in a tumblerful of it, and administer while effervescing.

I used to make it one of my "forethoughts" during the first stage, to have the materials all ready for a nice cup of tea, to be handed to the patient as soon as the binder was applied; but more recently I have acquired the habit of carrying one of those triangular bottles of Armour's Beef Extract in my satchel, and immediately after the delivery of the placenta, while the nurse is preparing the babe for the bath, to make a nice cup of beef-tea for the mother; and one for myself, generally. That the novelty of having something to eat, made by the doctor himself, is pleasing to the patient, and she is in a frame of mind to be very grateful for any little attention, is not the best consequence of this service. Five times out of six the comfortable feeling in her stomach produces drowsiness, and often I leave her in a beautiful sleep.

In arranging the dietary for a lying-in woman it should be remembered that the blood is deficient in albumin. The red corpuscles are materially diminished in number, the ratio to normal being, according to Becquerel and Rodier, as 111.8 is to 127.2. Cazeau insists that the pregnant state is essentially analogous to chlorosis, but Willcocks<sup>21</sup> shows that in the pregnant state the individual blood-corpuscles are

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<sup>21</sup> "Observations on the Blood in Chlorosis and Pregnancy," by Fred. Willcocks, F.R.C.P., in *Lancet*, Dec. 3, 1881.

quite normal in appearance, and are simply lessened in comparative number. There is, also, toward the end of the pregnant epoch, more or less drain of sugar and albumin, in the urine. These losses must be made up by efficient feeding.

Then, in addition to this, it must be remembered that there is a great quantity of effete material thrown into the mother's system after labor, and to get rid of this promptly requires a well-toned nervous system, which can be secured only by plenty of food and plenty of rest. In regard to the first of these our best guide, of course, is the feelings and desires of the patient, and while I can, on theoretical grounds, imagine many wise restraints to be observed, yet in actual practice I am a high-feeder; and have not in a single instance to regret it. It is my endeavor to so conduct the lying-in that the woman may say when the babe is a month old that she never felt better in her life; and I do very usually hear that. Absolute rest I get as much of as possible, coaxing along for one day more, and one day more, and making the progress from bed to lounge, and lounge to easy-chair, and easy-chair to the next room, and so on, as gradual as possible. The involution of the uterus takes two months; and while after the first two weeks, in ordinary cases, if appetite has been good, sleep abundant, and spirits tranquil, only moderate caution is necessary, yet I do my best to eliminate all chances of subinvolution, and its train of miseries. This may not be in the interest of my fellow-laborer, the gynæcologist, but he must excuse my lack of fraternal thoughtfulness. To the child just born it is the greatest service within my capacity. An enfeebled mother makes an unhappy child. How many a blow have I seen struck, how many a fretful speech have I heard, because the mother was impoverished in blood and worn with overwork.

*(To be concluded.)*

## CASE FROM PRACTICE.\*

BY

H. A. WHITMARSH, M.D.,  
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Mrs. —, æt. thirty-nine, married; one child twelve years old; four miscarriages since; menstruation regularly established at twelve; health fairly good; inclined to hysteria. In 1879 was ill in bed about two months with an "enlargement" in right side, attended with much pain. During this time there was a watery discharge per vaginam, gradual at first, but increasing in amount and frequency, often gushing forth without warning.

Prof. White, of Buffalo, in consultation advised laparotomy, came indeed on one occasion prepared to operate, but refrained, and treated the case with local applications of chromic acid. The discharge, however, continued more or less regularly for a year or more.

Moving to Massachusetts in 1881 or 1882, a portion of the fluid was submitted for examination to Prof. Wood of Harvard, and after careful analysis pronounced it as from the fallopian tube. About this time an "Indian doctor" of Boston was consulted, who gave a "strong medicine" that made her very sick, but brought away (as he had predicted) a sac that was expelled, preserved by the family, and carried to this "doctor."

In 1885 the patient came under my care, much reduced by a persistent vomiting that had baffled her attending physician for several weeks. Replacing and retaining by pessary the retroflexed uterus promptly cured this obstinate condition.

The watery discharge, above mentioned, recurred once or twice. A small amount gathered for examination I found

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\* Read before the Boston Gynæcological Club.



to be perfectly clear, in *sp. grav. lighter than water*. It also kept sweet indefinitely in a well-stoppered bottle. No sediment could be found sufficient to determine anything by microscope. During this sickness there passed per rectum shreddy membranous material, of which this sample is a part. Microscopically it appeared fibrous tissue with cells like those of lipoma.

Later that year I repaired existing lacerations of cervix and perineum, after which she gained rapidly in health and strength, and continued unusually well till the spring of 1888, when, from overwork and leaving out the pessary, the old displacement, with nausea and vomiting, recurred. My successor who attended her reported severe pain in left iliac region, considerable dullness on percussion, and tenderness to touch. Also slight rise of temperature. Called by him in consultation I found the uterus retroflexed and retroverted; an ill-defined mass to left which I regarded a dilated tube. Though considerable tenderness was present I advised immediate righting of the uterus, believing that nothing else would relieve the nausea that had made her general condition already critical. This was accordingly done, and the vomiting ceased as before.

Would add here that I found the uterus normal in size, and no sign of swelling, pelvic or abdominal, except the left tube already mentioned.

But the watery discharges had again appeared, and my suggestion that they could be cured by operation was not well received. Still the patient was gaining rapidly, and suffered merely from the drenching that recurred without rule or reason. A competent specialist of Providence, R. I., was consulted later, but his examination simply confirmed my own. Uterus 3 inches in depth, retroverted; left tube dilated; a dullness in *right* iliac region, but no outline as of a tumor. He advised laparotomy, and was likewise dismissed.

About Jan. 1, 1889, the discharges ceased on the expul-

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sion at intervals of three different sacs or membranes, now in the possession of the present attending physician. One is evidently the cast of a tube 3 inches long and thick as my finger. The second is a thin, smooth membrane which the doctor says he removed himself from the uterus. The third is in pieces sufficient to indicate a sac eight or ten inches in diameter, which he thinks came from the right side.

He says he found a tumor on the right; also that before the discharges ceased the uterus itself was at one time as large as at full term. The quantity of fluid passed at one time was caught, measured, and found to be, the doctor assures me, *two gallons*, all passing suddenly within a minute.

I leave this phenomenal case without comments, stating simply that until satisfied by observation as to the essential facts, my credulity was severely taxed.

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MISCARRIAGE AT ABOUT THE THIRD MONTH,  
PROBABLY THE RESULT OF A UTERINE  
FIBROID.\*

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BY

ROBERT HALL, M.D.,  
PROVIDENCE, R. I.

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Mrs. C——, age thirty-nine years; married about two years to second husband; first husband having been dead eighteen years; miscarried at the second month while living with first husband. She was usually quite well; menstruation regular and normal up to last May. About the first of July she consulted me with regard to the cessation of the menses. She had no subjective symptoms of impotance at this time, not even nausea.

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\* Read before the Boston Gynecological Club.

Examination of the uterus revealed considerable enlargement of that organ, more than I expect to find at this stage of pregnancy, even if that was the case. I rendered a doubtful opinion at this time, and requested her to call again.

She called the second time about the first of August. She reported that she had noticed a slight show of blood once or twice since I last saw her—one other symptom she had observed, that of an unusual appetite for apples.

On instituting another examination I found a perceptible increase in the size of the uterus.

I resorted to ballottement, which gave the unmistakable evidence of pregnancy. I at once gave a diagnosis accordingly. On the 26th of August I was called to see her at her house, at which time she had a profuse hæmorrhage, which soon ceased. It was not attended nor followed by any uterine pain; and when I saw her the next morning she was feeling very comfortable.

I heard nothing from her after this, until the 7th of September, when I was again called and found her having another large hæmorrhage, which was attended with syncope and uterine pain, and she was very much exsanguinated.

Digital examination did not reveal any perceptible dilatation. The abdomen was very much distended, and very sore to the touch. I at once resorted to the tampon, at the same time requesting the nurse to give her brandy. She stated that she had been having slight flowing about once a week since my previous visit.

The uterine contractions continued to increase for about three hours, at which time the tampon was removed, and found sufficient dilatation to allow of the passage of the finger.

In about three hours more the fœtus was expelled. I will say here that the hæmorrhage ceased with the placing of the tampon.

The pains continued for several hours with increasing

severity ; but they did not prove effectual in expelling the placenta. I thought best at this time to give an anæsthetic, and remove the secundines with the hand. While doing this operation I found a tumor in the anterior wall of the uterus nearly the size of the fist. I have no doubt that the tumor is interstitial. The womb was washed out with carbolized water; and the patient left in as comfortable a condition as possible. A moderate dose of morph. was given, and stimulants as occasion required. Arn. 3d and bell. 3d were given every two hours, and alcohol and water applied to abdomen.

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### STERILITY.\*

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BY

W. W. FRENCH, M.D.,  
CHATTANOOGA, TENN.

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It seems but proper that we should define the word Sterility. Dunglison says : "It may be absolute or relative, the former depending upon the conformation of the genital organs, apparent or concealed, and occasionally cured; relative, when a female does not conceive with one individual and does with another." Absolute, must be born barren or without the necessary organs of inception; therefore the necessary accompaniments to conception, whether in animal or vegetable, are *good* seed, planted or deposited in a fertile soil. Thus, with the human spermatozoa, it must be healthy and strong, and the ova fully developed and ready to receive. Some few have expressed theories, and none are of an exact counterpart, as to where conception takes place.

Our medical journals have had very little to say upon

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\*Read before the Southern Homœopathic Medical Association.

this subject; I know of no reason for their silence, save that it has been a subject of so little investigation by physicians, they thinking it too sacred a topic to discuss publicly. To my mind, the more sacred the theme, the more need of discussion, that the world may be the better educated.

It is said that Drelincourt, who lived in the seventeenth century, collected from the writings of *his* predecessors two hundred and sixty-two "groundless hypotheses" concerning generation. Blumenbach, in commenting upon this, says: "Nothing is more certain, than that Drelincourt's own theory was the two hundred and sixty-third."

These theories were divided by Haller into three divisions: The "spermatists," that fecundation was exclusively owing to the "sperm" of the male. "The ovists," who believed and expressed that fecundation was wholly endowed in the female. "The syngeneses," who believed that conception and its products were due to the union of both male and female. The second of these theories, (ovists) were again divided into "evolution," that is, the new animal is rendered visible by being "expanded, unfolded, or evolved" from a previously existing though impracticable condition of the germ. The "epigenesis" theory was "that a newly formed amorphous material was produced in the ovum." The "spermists" claim that the sperm entered the ovary and was held and retained there by a "valvular apparatus." The ovists' theory is that the female affords all the material necessary for fecundation and generative growth, the male only awakening the dormant power necessary for the development.

The other theory (syngeneses) is supported by Bufford and Needham, who claimed "that certain molecules called organic were contained in vegetable and animal life, being endowed with productive powers," which, when placed in suitable situation, were attracted toward each other, and their combination and union was "living organized bodies."

While there may be good grounds for these different theories, the more recent writers are inclined to the latter. I am a "*syngensis*," and hold it to be the only deduction that can be fully substantiated and maintained.

We notice, that with all vegetable and animal life there is the male and female. How true, whatever the life, it is necessary if an increase is desired, we must have both the male and the female. This is proven in the vegetable kingdom, as well as in the lower animals, and that the female must be in a certain condition (called "heat") or there is no issue and increase in number. Then, is it not natural to suppose, that the same conditions are necessary in the human female or woman? Unless the original formation of woman "from the side of man" endows her with some of the same sexual instincts as man has, that she may fecundate at any time after puberty.

I am brought to this conclusion, that, during the coition of man and woman, the ovum is set free from the ovary and the spermatozoa set free from the testes at the same time, and they seek and unite in the uterus, and such joining and combining go to the formation of a newly "organized living body." During the act of copulation, the action of the tissues of the female, especially those of the uterus and its immediate appendages, is of a sucking or drawing motion; thence, with this action, the spermatozoa is drawn into the womb through its os and neck, and there met by the ova, when the union takes place which forms this "new life." Should this action of the female tissues suspend, before the sperm of the male is injected into the vagina of the female, there can be no uniting of the two materials and consequently no conception, and sterility is the result with that individual. Now, should the injection be premature, then the ova would not have time to travel to the uterus and the sperm die for want of its mate.

There are other conditions necessary to fecundation. The walls of the uterus need to be healthy and in a suitable

state, that the new life may cling to it, and thereby be nourished. Should there be an acid leucorrhœa, it would kill the spermatozoa before it could reach the uterus; should the muscles of the os and neck be flabby and inactive, they would fail to aid the union of the "vital fluids," or, if they did unite, force of gravity would return the "*union*" to the vagina, where its fluids and air would kill it: should there be metritis or endometritis there would be no place for the "*union*" to cling to or be fed if it did; should there be tumors, or anything to close the os or neck, then there could be no conception; misplacements, or flexions of the womb might interrupt this union of the two forces by keeping the sperm out of the uterus; there might be diseased ovaries, or cysts, or tumors, or stoppage of the fallopian tubes, that would keep the ovum from entering the uterus. Anæmia, or hæmorrhage, or profuse discharges, chronic troubles of the vagina, besides malformations of the female, might cause the sterility of the woman. Now with the man: I firmly believe many ladies who are pronounced sterile, would fecundate, if the husbands were more considerate, and waited till the lady desired. In the lower animals, we notice *no* copulation until the female is in "*heat*," and that each female has her regular periods of desire: this law *should* and *ought* to hold good with the human race. There may in some cases be a want of "vital fluid" in man, who has abused his sexual organs, thereby weakening the injective force, or loss of "*man-fluid*," before the coition is fully accomplished; there may be some deformity in his organs, as well as the female—phimosis, sexual excess, excessive venery, gleet or catarrhal discharge, atrophied testes, hypospadias, etc.; certain it is, to fecundate, there must be a shedding of healthy and mature ova from the ovaries and unobstructed fallopian tubes, healthy walls of the uterus and its appendages, a healthy condition of the vagina and all erectile tissues of the female, with all the

organs of the male equally strong and healthy, to have well, stout, robust, perfectly formed "new organized life."

I know I am on debatable ground, and many experiments have been made; but, to look at the matter from nature's standard, which is the only true one, I can see no need of sterility, save congenital malformation. That it does exist is as certain as that it has been corrected. Cases are known where man and wife have lived for years without issue, and then have children; this accomplished by treating the wife and insisting that the husband should abstain from all intercourse for months; other cases, where the twain had over-indulged, when the wife was sent away from home for a few weeks, and upon her return became pregnant. One great wrong is, man seems to feel and act as lord over woman, insisting upon gratifying his own personal feelings, whether the wife is willing or no.

The disposition and aim of a majority of wives of *to-day* is not to have children. This is a very bad, pernicious, wicked, ungodly, unchristian, and unholy mode of life, and many a one has caused the life of a legitimate fœtus to die, while trying to keep from bearing children. The dress of the female from puberty to marriage, and even after, has a great deal to do with "barrenness." Were corsets and tight-lacing discarded, women would have better health and enjoy all the pleasures of married life much more than now.

To cure sterility, is to remove the cause when found; if tumors non-malignant, removal will often succeed; if leucorrhœa, medicines internally and locally will accomplish the end; the character of the discharge, its color, quantity, quality, painless or not, time of day and other concomitant symptoms need to be carefully studied, then select the drug to correspond; if weakness is a cause, tone up the patient with nourishing food, and bathe, with friction; if metritis or endometritis, insist upon cessation, totally, of all sexual intercourse for a period of weeks, perhaps of months, and treat the trouble. Galvanism and faradism have been used



with more or less success. I find such remedies as boras, phos., arsenicum, nux vom., china, gelsem., hydrastis, hamam., nitric acid, and phos. acid, with sepia, silicia, hepar, and sulph., as among the better medicines. Non-intercourse is my strong point; if there are misplacements or flexions of the uterus or closure of any tubes or canals, they must be corrected. I have written this, hoping that this too much neglected subject will receive attention from some of our older practitioners, that the growing age may reap a reward from their sowing.

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## ● EDITOR'S TABLE. ●

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NOW and then, since the general introduction of Credé's method of delivery of the placenta, we read and hear of cases where so-called syncope has ensued in the third stage of labor or immediately thereafter. The uterus has been a little relaxed, and there has possibly been a slight threatening of hæmorrhage. The syncope in such cases has been ascribed to the trifling loss of blood, often but little in excess of what we would expect in a normal labor. But Dr. J. H. Ferguson (*Edinburgh Medical Journal*) takes a different view of the cause of syncope with such a history. In his opinion the syncope should be attributed to the energetic and forcible kneading which the ovaries, along with the uterus, have been subjected to, by the over-zealous but well meaning accoucheur in his efforts to apply Credé's method to avert a more or less visionary post-partum hæmorrhage; the so-called syncope being the result of shock pure and simple. At the root of such unfortunate results lie the improper teachings of those authorities who have done much to popularize Credé's method. Thus the general statement has been,—“The hand grasps the uterus in such a way that its ulnar side sinks deeply down behind it, the entire hollow of the hand lying on the fundus and the thumb on the anterior wall.” Now, as is well known, the uterus in pregnancy becomes usually rotated to the right on its longitudinal axis, so that the left ovary comes to be more anteri-

orily, while the right ovary lies more posteriorly. Then, if the beginner in obstetrics has not recalled this fact, he is sure to make a mistake and follow Grandin, who distinctly states that in order to grasp the uterus antero-posteriorly the ulnar side of the compressing hand must be in relation to the promontory of the sacrum posteriorly and the thumb behind the symphysis pubis." But in this position, as seen from the rotation of the uterus to the right, the uterus is not grasped antero-posteriorly and the ovaries are in imminent danger. To make sure then of grasping the uterus antero-posteriorly, the hand should be passed into the form

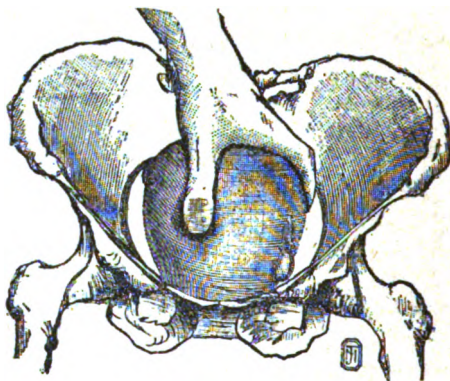


Fig. 1. Diagram to show the oblique position the uterus occupies in the pelvis after the second stage of labor. The uterus is represented as being pushed down in the pelvis by the hand, which is grasping it antero-posteriorly. Note the oblique position of the hand in relation to the pelvis. It will be seen that the right ovary lies on a higher level than the left.

of the pelvis obliquely, the ulnar side of the hand pressing down deeply in the direction of the left sacro-iliac synchondrosis, while the thumb should be behind the right ilio-pectineal eminence, the uterus resting in the hollow of the hand (as in Fig. 1).

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—According to Petresco (*Gazette Médicale*) the root of *Bryonia alba* possesses some hemostatic properties analogous to those of ergotine and hamamelis virginica. With the alcoholic extract, in doses of 30 to 45 grains a day, he has obtained good results in the treatment not only of metrorrhagias but of epistaxis and hemoptysis. A glucocide has also been extracted from the root

with which experiments have been conducted on rabbits and frogs. To this glucocide the name *bréline* has been given, from the popular name *bréti* which the plant bears in Roumania. By subcutaneous injection 20 grains of *bréline* are well supported by dogs and cats, though in this strength it is poisonous in rabbits.

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—Professor Peter (*Revue Médico-chirurgicale des Maladies des Femmes*) comes out boldly in a late clinical lecture in favor of simple injections of water as a preventive of puerperal infection. He discards entirely, as dangerous, all medicated injections and concludes that *cleanliness*, exclusively cleanliness, is the best prophylactic, aseptic, and and antiseptic.

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—*Cyclamen* and *Pulsatilla* are remedies that are often difficult to differentiate. They are both suited to chlorotic and anæmic women and they both have some trouble with digestion and intolerance of fatty foods. Both have chilliness with the pains, crying, tearful mood, and menstrual colic. Both have "aggravation in the evening" and "relief from moving about," but *pulsatilla* has prominently relief from a *cool room* or from being in the "open air," while the *cyclamen* patient is worse in the "open air." *Cyclamen* is better indicated in too frequent and too profuse menstruation "*with flow of black clotted blood*," while *Pulsatilla* corresponds better to *scanty or delaying* menses. *Pulsatilla* has *thirstlessness* with all complaints, while *cyclamen* generally, but not always, has *thirst* as a symptom of the trouble to which it is adapted. The *cyclamen* patients suffer from a peculiar debility of mind and body. When they awake in the morning they are sleepy and tired; feel so heavy and languid that they can scarcely drag around at first, but when once at work and forced to exercise they feel better. With *pulsatilla* we find much the same symptoms, but it is especially in the fresh cool air of "out-of-doors" that the afflicted woman finds relief from her tired, worn-out feeling. Finally there is the transient obscuration of vision that is characteristic of both remedies. In *pulsatilla*, however, the temporary blindness generally appears during menstruation or as a consequence of suppressed menses. In *cyclamen* the obscuration

of sight is more characterized as being accompanied by semi-lateral headache of the left temple, with pale face, and nausea referred to the throat.

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—Leucoplasia vaginæ we have seen in the form of whitish patches on the vulva, but it is so rare a disease that the thesis which Dr. Bex (*Gazette de Gynecology*) devotes to the consideration of this affection contains a number of valuable observations. In the beginning, vaginal leucoplasia probably passes unnoticed during a long period, for it is indolent in character, causing no inconvenience except a slight itching. The spots or patches which constitute this affection are at first opalescent, transparent, allowing the mucous membrane of the vagina or vulva to show through them; but, little by little, the epithelial layer thickens and becomes opaque, and then the color varies. Sometimes it is silvery white; at other times the tint varies to the white of a kid glove. The surface is a little rugose, and at points are detached pellicle, or scales, pearly shreds similar to those observed in buccal leucoplasia. Again, the color may be bluish, or creamy, or similar to that of cheese. The papillæ of the membrane are hypertrophied; over points where the membrane is denuded there ensues an appearance somewhat resembling a raspberry. The shape of the patches, as well as their extent, is extremely variable. The plaques are sometimes hard and very sensitive to touch. There sometimes exists a stiffness or marked thickening at the edge of the vestibule. This augmentation is probably due in part to a thickening of the epithelial layer, but it especially is due to the production of fibrous tissue in the membrane and in the subjacent parts. The indurated papillæ may sometimes be productive of difficulties in diagnosis. The thickening may simulate a chancroid. With regard to the etiology of leucoplasia of the vagina little is known. M. Besnier has observed it a number of times among diabetic individuals, but, further than this, it can only be supposed that this affection may have its origin in any of the causes that give rise to an irritation of the mucous membrane of the vulva or vagina.

As to treatment: during the stage of slow progression, Dr. Bex only advises alkaline lotions after each micturition, and the appli-

cations of some pomade intended to prevent the contact of irritating discharges. As soon, however, as the epithelial degeneration, to which it has a tendency in a late stage, is perceived, surgical measures are necessary.

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—Many authorities have cited menstrual trouble and metrorrhagias as a consequence of alcoholism among females. This is denied by Dr. Thomeuf, of Lorient, France, in *L'Art Medical*. This author claims that menstrual disturbances are no more frequent among females addicted to drunkenness than among those who are not. With regard to miscarriages in this condition they are nearly all to be traced to syphilis. The author further reviews a number of other statements as follows :

According to Dr. Casanova, the sexual desires are diminished and even abolished among those addicted to alcohol, and this phenomenon will be more striking and more frequent among patients who use alcohols mixed with essential oils. We admit up to a certain point the truth of this observation for *men* and those affected by chronic alcoholism, but we have not found this correct in females affected by sub-acute alcoholism. Here there is not a lack of tonicity of the sexual tissues with loss of sexual desires as has been affirmed, for we have found the alterations of the sexual system among those females affected by sub-acute alcoholism to be in the nature of excitation, accompanied by a diminution or by a total loss of shame. If conception follows among this class, labor is normal, but in the puerperal state grave complications are frequent as a consequence of the lesions produced by alcoholism.

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—M. Doléris (*La Gazette Médicale de Montreal*) has something to say on the functions, pathology and surgery of the cervix uteri, from which we gather a number of points worth reading, and particularly does he teach us a lesson on the *after-effects* of caustics and astringents that some of us ought to carefully consider.

Taken as a simple passive canal, the normal uterine canal has in its general configuration an almost rectilinear direction ; it is *only* slightly curved at the isthmus. Its calibre is always sufficient for its function. The structure of its membrane and the

shape of its walls assure, by a kind of drainage apparatus, the permeability of the organ in two directions, from within outward, and inversely.

The moderate secretion of cervical mucus is not unfavorable to its function. The primordial rôle in the initial phenomena of fecundation belongs incontestably to the os uteri.

Among women who have had children the vaginal canal is larger, but the uterine orifice is more open and much more accessible than in those who have never had children. In this manner the normal aptitude to successive fecundations is preserved.

When an excessive deformation vitiates these reciprocal dispositions of the vagina and cervix uteri, the aptitude diminishes and even disappears.

The muscular tension of the stroma of the cervix responds to various active phenomena in relation with its function.

The cervix acts as a sphincter during gestation and during the first phase of parturition. The rôle of the muscular sphincter is greatly aided by the vascular circle which surrounds the cervix in its subvaginal portion, and which constitutes in the uterine isthmus a true erectile tissue at the edge of which the muscular fasciæ are reduced to an areolar membrane. The maintenance of the muscular tissues and the integrity of the nervous influx are the guarantees of the resistance of this region.

All the pathology of the cervix uteri is contained in three words, traumatism, inflammation, and degeneration or neoplastic processes. Cervical endometritis causes ectropion of the mucosa of the cervix, just as rectal inflammation causes hernia of the rectal mucous membrane.

*Caustics and the thermo-cautery cause transformation of the cylindrical epithelium, thus lining all the cervical ectropion by a solid pavement-like coat. From this we have obliteration of the ducts of those glands which open on the surface of the ectropion. What happens now? The secretions of the glands are retained and produce chronic tumefactions.* [The foregoing sentences are so full of warning to those who are active advocates of local treatment by caustic preparations that we feel it important to italicize.] Under the *cicatrix* thus formed ensue processes which

have escaped many observers. The glands are altered, filled by the products of secretion, and enclosed under a corneous envelope. From time to time there appear at the surface follicles filled sometimes by pus, a proof that infection exists in the depth of the tissue. The last stage of this chronic lesion is cystic degeneration with invasion of the sclerosed tissue by cysts. These disturbances cause elongation of the cervix, atresia of the cervical canal, deviations, etc. They occasion also the awakening of salpingo-ovarian affections.

The vascular sphincter permits us to understand localized spasms of the internal orifice. Precocious atheroma, constitutional or acquired enfeeblement of the arterial walls, etc., cause loss of the firmness of the structures at the junction of the cervix and body of the uterus, with atony of this middle segment and flexion at the isthmus.

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## ● GOLDEN GRAINS. ●

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—Urticaria in children is nearly always in relation with passing or permanent digestive troubles. Dentition does not appear to exercise any influence in its production. Chronic urticaria, after presenting from six months to two years, may give place to pruriginous papules, accompanied by the lesions of scratching, fissures of the skin and eczemiform plagues, the prurigo of Hebra, and thus be of grave prognosis.

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—In the diarrhœa of children *Secale* like *Arsenic* is indicated by profuse undigested stools, which are watery and very offensive and produce intense prostration. But there is always the great distinction, that under *Secale* the patient wants to be cool, while the *Arsenic* patient wants to be wrapped up warmly.

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—In making local applications to the female sexual organs, it is well to reflect carefully on what may be the *secondary* effect of the agent that is selected. We have seen cases of uterine devi-

ation cured (?) by means of tampons of cotton soaked in glycerole of tannin, in which at the end of six months the prolapsus was worse than before the cure, for the reason that the secondary effect of the tannin was to produce a relaxation of all the vaginal tissues and to lessen the tone of the the venous circulation.

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—Dr. Herbert Spencer calls attention to the importance of abdominal palpation in pregnancy (*British Med. Jour.*, Dec. 14, 1889). Advantage should be taken of the thinnest parts of the abdominal wall, namely, the linea alba (especially in multipara), the linea semilunaris, and the umbilical region. In early pregnancy, when deep pressure has to be made, it is sometimes useful to examine with superposed hands. Particular attention is directed to the advantages derived from abdominal palpation late in pregnancy and in labor. The outline of the uterus having been determined by palpation the surface should be explored, the contraction under the manipulation and the movements of the child noted, the round ligaments felt as two soft cords passing downwards at the side, of the front of the uterus, the pulsating uterine arteries, and sometimes the uterine thrill at the side of the lower fragment may likewise be felt. Abdominal ballotement is best obtained from the fifth to the eighth month, but can sometimes be detected in the latter part of the first half of pregnancy, by placing the two hands at the sides of the lower segment and giving with the left fingers a pushing movement to the uterus, at the same time rhythmically depressing the fingers of the right hand at the rate of four or five times a second; the course of the fœtus, from left to right, being suddenly checked by the fingers of the right hand, gives rise to a very distinct sensation.

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—There are a few remedies, pointed out by Farrington, that are worth a brief review in their associations with tardy appearance of the eruptions of the exanthemata, or with suppression of the rash. Under bryonia the eruption comes out imperfectly, and meningitis follows. The child's face is red, or else it is red and pale alternately. The rash has not the smooth character of belladonna, otherwise there are many symptoms similar to this last-



named drug. The child screams out suddenly, apparently with sharp lancinating pains, and this is especially manifested on moving the child. There is marked squinting with one or both eyes. The bowels are usually constipated, the abdomen distended, and the child has marked sensorial depression, bordering on stupor. With all this benumbing of the senses there are no absolute hallucinations as under belladonna; the child does not awaken from sleep clinging to those about them, as with stramonium or cuprum.

In like cases, suppression of eruption with consequent effection of the brain, cuprum is the remedy when the symptoms are violent and the characteristic spasms indicating this remedy are present.

Zincum is to be preferred if the child is too weak to develop an eruption. The eruption comes out sparingly. The surface of the body is rather cool. The child lies in a stupor, grating its teeth, it starts up during sleep. Squinting and rolling the eyes are observed, and there is marked fidgetiness of the feet.

Ipecac is to be thought of when the chest is affected from the recession of the rash of measles, when there is difficulty of breathing, wheezing, rattling respiration, etc.

Tartar emetic ought to be given in preference to bryonia when the disease, in which the eruption is tardy or suppressed, is variola. Camphor may also be of use in suppressed eruptions where delirium, mania, or convulsions exist, with the characteristic coldness and extreme prostration.

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—The fact is stated in text-books, and in monographs relating to infant-feeding, that infants under the age of three months are able to digest only a very small amount of starch, since the glands which secrete saliva, which is the chief agent in digesting starch, exist in an almost rudimentary form until after the third month. But starch, converted into dextrine by the prolonged action of heat, can be digested by the youngest infants. Now and then we find cases in which this fact can be utilized with great advantage. By long boiling (two and a half to three hours), and careful straining, wheat, pearl barley, or rolled oats can be made so digestible that it can be substituted for many of the various prepared infant foods.

—*Jacaranda*, a South American plant introduced by Muir, has been recommended as an excellent remedy for chancroid-like sores about the external genitals. *Corallium rubrum* is also mentioned in this connection as a remedy for chancre-like sores that are very red.

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—Dr. G. R. Adam reports (*Australian Medical Journal*) a case of iodism from a single intra-uterine application. For a heavy retroverted uterus an intra-uterine application of Churchill's iodine formula (iodine 75 gr., potass iodid. 90 gr., spt. V. R.  $\frac{3}{4}$  j.) on a probe was made, with expectation of relieving the endometritis. On the following morning the patient had suffusion of the eyes, coryza, etc., which subsided in a couple of days; but both upper eyelids were pigmented and eventually desquamated. The pulse and temperature remained normal throughout, notwithstanding that the patient was excitable and restless.

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—The obstetrician should never substitute himself for Nature, when she is able to successfully conduct labor alone.

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—In cases of otalgia in children the intensity of the pain is not always in relation with the gravity of the disease. A furuncle of the auditory canal may cause as much suffering as a high grade of middle ear inflammation.

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—In cases of uterine displacements complicated by ovarian prolapsus, before attempting to introduce a pessary, be sure that the ovary is not fixed by adhesions that will be dragged on by the instrument.

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—Mademoiselle Goldspiegel (*Journal de Médecine Pratique*) publishes a series of observations showing that hysteria is far from being rare among children, no matter what sex, the fifth part of the hysterias occurring before the age of puberty. All the symptoms of hysteria as it presents itself in the adult may be observed in children. The prognosis of infantile hysteria is regarded as generally favorable and better than when occurring

among adults, especially if the disease is cared for early ; but, in order to obtain the best results, it is often necessary to separate the child from its parents.

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—The transmission of tuberculosis to children by means of milk is receiving the attention of the French Academy of Medicine. On this question the *Revue Sanitaire* gives the following conclusions formulated by the academic commission :

The milk deserves especial attention from mothers and nurses by reason of the aptitude of young children to contract tuberculosis. [There die annually, in Paris, more than two thousand tuberculous subjects of less than two years of age.] The tuberculous mother should never nurse her children. The child of tuberculous parents must receive the greatest care with regard to its hygienic and prophylactic surroundings. It should be confided to a healthy nurse, and should pass its early years in the country in a house free from all chances of tubercular contagion. Nourishment at the breast being impossible, this must be replaced by artificial feeding with boiled cow's milk. If asses' or goat's milk can be obtained there will be infinitely less danger than in the use of cow's milk.

## ❁ GYNECIC ETCHINGS. ❁

—H. C. Allen, M.D., has written an admirable *résumé* of the pathogenesis of "MAGNESIA PHOSPHORICA." We borrow therefrom so much as promises to be of use in gynæcological practice.

CHARACTERISTIC.—*Is best adapted to lean, thin, emaciated persons of a highly nervous temperament ; but acts equally well in stout persons when well indicated.*

Affections of the *right side of the* body, including right ovary.

PAINS.—*Sharp, cutting, piercing, stabbing, knife-like ; lightning-like in coming and going ; often and rapidly changing place.*

In the abdominal region *Magnesia phos.* has "cramps in the abdomen, pains around the navel and above it toward the stomach,

and from thence radiating to both sides, toward the back ; now violent, cutting so that she has to scream out, then shooting and violent contracting like a spasm. She cannot bear to lie on the back stretched out, has to lie bent over " (Koeck).

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—With regard to the FEMALE SEXUAL ORGANS *Magnesia phos.* presents the following, according to Dr. Allen's pathogenesis : Menstrual colic ; ever since I began taking the medicine I have menstruated from six to nine days too soon. The second period was accompanied with great weakness and an intensely sore, bruised feeling all through abdomen, so that I could hardly be up at all, but was much worse lying down. Painful swelling of the external genitalia began the second week of proving and continued with varying degrees of intensity for six weeks ; labiæ swollen and at times intensely painful. Dysmenorrhœa ; pains severe, intermittent, worse on right side, relieved by heat. Pain relieved by flow.

Membranous dysmenorrhœa. At each menstrual visus severe, sharp, shooting pains in lower abdomen after the flow began, followed by discharge of a membrane from one to two inches long. The menstrual pains are cutting, drawing, pressing, cramping, intermittent, resembling the menstrual and labor pains of Pulsatilla, but unlike Pulsatilla are relieved by heat.

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—Finally we may finish this brief *résumé* of *Magnesia phos.* by a comparison with *Cimicifuga* made by Dr. A. P. Davis, of Dallas, Texas, according to his clinic experience : " In *Cimicifuga* there is more of a *steady pain* and in *Magnesia phos.* a *shooting spasmodic, darting, 'like lightning pain'* which comes and goes *suddenly*, yet at the same time *not an entire cessation of the pain*.

"The pain of *Magnesia phos.* seems to be in the ovaries and not in the 'broad ligaments,' nor so much in the cervix as in the fundus of the uterus, and seems to be more in the deeper structure, the muscular than the ligamentous, as is the case with *Cimicifuga*.

"The action of *Magnesia phos.* is quicker than *Cimicifuga*. The experience I have had with *Magnesia phos.* is that the pains

that come on several hours before the menses, are controlled better and sooner by the use of Magnesia phos. than any other remedy. They affect principally the lower abdominal region and have a peculiarly indescribable character nearly all the time, and frequent shocking, darting paroxysms until the flow starts, then they cease. "The effects of Magnesia phos. in relieving menstrual pains are decidedly satisfactory—I regard it as superior to Cimicifuga, even in neuralgia of the uterus. Ovaritis seems to be controlled by it from its effect, not only in relief of the pain, but curatively from its mechanical action on the walls of the blood-vessels—contracting them, and thus relieving the congestion."

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—Dr. M. Duncun has described, under the title of aching kidney, a condition, especially common in women, which may simulate a renal calculus. Its chief features are a heavy wearing pain deep in the side, usually accompanied by tenderness, often very great; the pain often runs along in the course of the great sciatic or anterior crural, and is often accompanied by irritability of the bladder, and, frequently, by pain in the course of the ureter. The disease is liable to be aggravated by exercise. The chief points in the diagnosis of this condition are the absence of pus and blood, and the fact that the "aching" often occurs only at the menstrual periods and is always worse then, from the intimate connection between the kidneys and the generative organs, not only developmental but pathological.

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—*Senecio aureus* will be found useful for some reflex troubles traceable to uterine irritations, or to flexions or prolapsus. It is especially suitable for nervous, excitable women. The patient suffers from scanty menstruation, in consequence of her uterine trouble and, as under pulsatilla, is apt to be tearful. The reflex symptoms are sometimes manifest in dry teasing cough, with stitching pains in the chest and blood-streaked sputum. In other cases we find a reflex bladder trouble with pain at the neck of the bladder, burning, and dysuria. That these various symptoms are reflex is manifested in the fact that after the onset of the menstrual flow the chest symptoms and cystic troubles are modified or ceased.

—Functional bladder trouble, true vesical irritation as a pure neurosis, occasional requires differentiation from true cystitis. Pain about the pubic region and pelvis generally, frequent and painful micturition, tenesmus, the sensation that the bladder is never emptied, going on day and night for weeks, producing emaciation, exhaustion, and a life of wretchedness, may be due entirely to purely functional causes. This should never be forgotten when passing in review all those varied affections—piles, and fissure, rectal ulcer, or worms—which may cause reflex bladder symptoms. Masturbation, producing congestion of the pelvic organs, is another cause. Diseases of the uterus, especially of the cervix uteri, and displacements of the womb are common sources of functional vesical disorders. Pelvic abscesses and tumors may also provoke these troubles. In differentiating from chronic cystitis it is pretty safe to conclude, when the urine is normal or nearly so that the disorder is functional and not true cystitis ; again, as a rule, with of course exceptions, when a woman has to void her urine frequently, and suffers pain in the act, but is relieved when the viscus is empty ; or, if she attempt to hold the water too long, spasm of the bladder comes on and the urine is involuntarily ejected in spurts, there the trouble is functional ; but when there is great and prolonged tenesmus, with pain and straining after the water has all come away, as a rule there is real disease of the bladder or urethra.

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— According to Legrand du Saulle and Mœrbins, *Neurasthenia* forms the germ of the disease from which, under the influence of heredity and predisposing causes, hysteria and the most diverse psychoses may develop. Admixture of healthy blood (divergent) weakens the hereditary influence so that we meet among the descendants only simple neurasthenia ; an accumulation of hereditary influences (convergent) through both parents produces grave neuroses, and finally the extinction of the race from physical and psychical degeneration. Converging heredity is also the cause of the degeneration and extinction of dynasties and of noble families, where diseases are kept up by intermarriage of blood-relations and of scions heavily weighted by disease germs. Hence the fre-

quency of nervous diseases and hysteria, and of physical degeneration in consequence of a long chain of converging hereditary neuroses.

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—Dr. Wm. Goodell, in the *Medical News*, offers some timely words on "The Abuse of Uterine Treatment through Mistaken Diagnosis." To those who work upon the supposition that some genital disturbance is at the bottom of every disease from which woman suffers, it would be well to quote briefly from this paper. In the first place, always bear in mind that another has pithily said, that "woman has some organs outside the pelvis." Second : Each neurotic case will usually have a tale of fret or grief, of cark and care, of wear and tear. Third : Scant, delayed, or suppressed menstruation is far more frequently the result of nerve-exhaustion than of uterine disease. Fourth : Ante flexion *per se* is not a pathological condition. It is so when associated with sterility or with painful menstruation, and only then does it need treatment. Fifth : An irritable bladder is more often a nerve symptom than a uterine one. Sixth : In a large number of cases of supposed or of actual uterine disease which display marked gastric disturbance, if the tongue be clean, the essential disease will be found to be neurotic ; and it must be treated so. Seventh : Almost every supposed uterine case, characterized by excess of sensibility and by scantiness of will-power, is essentially a neurosis. Eighth : In the vast majority of cases in which the woman takes to her bed and stays there indefinitely, from some supposed uterine lesion, she is bed-ridden from the brain and not from her womb. I will go further and assert that this will be the rule, even when the womb itself is displaced, or it is disordered by a disease or by a lesion that is not in itself exacting or dangerous to life. Finally : Uterine symptoms are not always present in cases of uterine disease. Nor when present, and even urgent, do they necessarily come from uterine disease, for they may be merely nerve-counterfeits of uterine disease.

\* \* \*

—Everywhere we see *Thuya occidentalis* brought forward as a remedy for syccosis, condylomata of the genitalia, but there is the

danger before us, in giving this prominence to this one remedy as a specific, that we are apt to pass in silence over a number of drugs that are as closely connected with fungous growths of venereal origin about the female genitals as is thuya. The condylomata of thuya appear on the vulva, on the perineum, about the anus, and even on the mucous surfaces of the internal genital organs. These warts may have a seedy look or they may be of a cauliflower shape, deeply fissured. When affecting the cervix they are especially apt to take this last condition. These condylomata are accompanied by a thick, greenish leucorrhœa. In other cases the warts are moist and ooze a glutinous fluid. Sometimes we find ulcers about the vulva and adjacent parts which bear many of the appearances of chancroids. They have a dirty yellow base with hard edges. Farrington in his *Clinical Materia Medica* says, farther than this, that these ulcerations are very characteristic of thuya if they seem to have originated from warts. That sometimes we note deep fissures, or furrows, about the anus and on the perineum. Among the remedies similar to thuya in these conditions, Kali bichromicum comes under the head of ulcerations affecting the vulva in sycotic constitutions. These ulcers extend deeply rather than superficially, have a hard base and a red and inflamed areola. There is an accumulation of tenacious discharge about the genitals. Nitric acid approaches very closely to thuya in condylomata of the vulva. It has also moist fissure at the anus, as under thuya, and greenish leucorrhœa. It may be distinguished by the aching pains in the bones, especially in those localities devoid of muscular-tissue covering, as along the tibia.

*Staphisagria* suits long filiform condylomata. It is preferable to thuya when there are present crumbling teeth and eczematous eruption with the formation of yellow scabs.

*Sabina* is useful for condylomata which itch and burn. *Euphrasia* is to be used when the condylomata look like a cock's comb. Under *cinnabaris* the figwarts are fan-shaped.

*Sarsaparilla* has moist eruption about the genitals, and this is also characteristic of petroleum, which has in addition "membranous shreds about the anus."



—The curve of menstrual age, compared with the curve of the onset of chlorosis, does not bear out the opinion that "foremost in etiological importance is the period of the first appearance of the catamenia." The fact of a periodicity in the attacks is also against it. Imperfect evolution, as evidenced by scantiness of the flow and irregularity of the periods, is as regular a feature of chlorosis as the imperfect evolution of the red corpuscles of the blood; these constants are not related to each other as cause and effect, but are independent one of the other; at the same time, however, there is a close relationship between them, whereby the reproduction and development of the red corpuscles of the blood are governed by, or form part of, the menstrual cycle; and both, furthermore, are influenced by a greater rhythmic action which determines the time and activity of development, growth, and reproduction.

\* \* \*

—The substitution of electricity for laparotomy in ectopic pregnancy has been a much discussed question for some time past. The trouble has been that electricians have refused to see the limitations of the measure that they advocate, while on the other hand the surgeons have refused to accord any therapeutic value to electricity in these cases. Careful study of the claims of both parties suggests some rules for guidance in the management of ectopic pregnancies:

1. *Electricity*.—If the diagnosis is made during the first three months, and if the symptoms have not exceeded in severity the early or premonitory signs of rupture, use electricity.

2. *Laparotomy*.—If the diagnosis is not made until the fourth month, and the severe symptoms continue, do a laparotomy, and remove the sac and contents in the most approved manner.

3. *Laparotomy*.—If a diagnosis is made at whatever stage of ectopic pregnancy, and if the symptoms are alarming, and undoubtedly due to rupture and loss of blood, do a laparotomy at the earliest possible moment consistent with the patient's ability to endure an operation.

4. *Delay a laparotomy until the seventh month*.—If the diagnosis is made after the fifth month, and the symptoms are less and less severe, the foetus undoubtedly not in the fallopian tube, and

the patient is anxious to bear a living child, and you are prepared to watch the patient, and be ready to meet, by laparotomy, at a moment's notice, any emergency which may arise, then delay is justifiable until the child is viable, in order that a laparotomy may be performed with the possibility and probability of saving *both* mother and child.

5. *Operate in best manner for removal of dead fœtus.*—When the pregnancy has continued beyond the ninth month, and the fœtus is found to be dead, the *amount* and *character* of *general* and *local disturbance* occasioned by the dead fœtus must determine when an abdominal section should be made, other operations performed, and the offending body removed.

\*  
\* \*

—*Bromine* is not often thought of in cancer of the mammary gland, but after careful study we have been testing it lately and find that it is sometimes useful. It requires careful comparison with *carbo animalis* since both remedies have, quite markedly, induration of the axillary glands with burning pains. But Bromine has also cutting pains. The breast is hard, and on palpation a dull, subdued sort of throbbing may be felt in it. Farrington says, of the cutting or drawing pain of Bromine, that this symptom is so marked that it feels as if a string were pulling from the gland into the axilla.

\*  
\* \*

—Emmett's operation was performed by Dr. Reamy, professor of clinical gynæcology in the Medical College of Ohio and gynæcologist to the Good Samaritan and Cincinnati hospitals, before the class at the Good Samaritan Hospital recently. He emphasized the fact that he did not insert first the stitch nearest the apex of the denudation but the second and third from the apex. His experience had been that it was very difficult to tell just how much tissue you were taking and just how perfect the coaptation would be on inserting the highest stitch first. The doctor after a thorough trial of all kinds of sutures has settled down on cat-gut in this operation. He advises that a suture large enough to fill the entire tract of the needle be chosen. He advises the cutting of the thread long, as a short, stubby suture is more apt to get between the surfaces which are in coaptation and prevent their union.

## CORRESPONDENCE.

A subscriber writes : I hope some one will give their *successful* treatment of ulceration of the cervix. I fail to find a cure.

EDITOR JOURNAL OF OBSTETRICS: In my article regarding the treatment of Sub-involution of the Uterus you make me say : "They made a very elegant suppository containing 1-16 of a grain of Elaterium to one dram of Glycerine," which is a mistake. I wrote it "Elaterin." A letter from Messrs. Parke, Davis & Co. informs me that they have had a number of applications for samples of the suppository. But some physicians wrote them that they had feared to apply the suppository, believing it would produce abortion. I will state for the benefit of the profession at large that I have used the remedy in thousands of cases, and in many cases where such results would have occurred had it been possible. I have yet to hear of the first case where there was any bad results from its use. And I can say with confidence that no such results may be feared.

WM. D. GENTRY, M.D.

## BOOK REVIEWS.

THE PRACTICE OF MEDICINE AND SURGERY APPLIED TO THE DISEASES AND ACCIDENTS INCIDENT TO WOMEN. By W. H. BYFORD, A.M., M.D., assisted by HENRY T. BYFORD, M.D. Fourth edition, revised, rewritten, and very much enlarged, with three hundred and six illustrations. Published by P. Blakiston, Son & Co. Philadelphia: 820 pp.

The author of this exhaustive as well as standard treatise is so familiar to the reading medical public it seems almost superfluous to attempt an introduction of the writer. The simple fact that the work has reached its fourth edition, although the market has been absolutely flooded with gynæcological literature during the past few years, is in itself a sufficient recommendation. Prof. W. H. Byford has long been recognized as a representative member of the profession, and especially is this true in his relations to the specialist in the department of "diseases peculiar to women."

The work has been divided into forty-eight chapters, each furnishing material of unusual merit and interest in the study of the subjects discussed. Our attention was especially directed to the clinical value of several chapters, notably, the second and third. Too much time and thought cannot be given the anatomy and relation of the pelvic structures as they are encountered clinically.

The chapters devoted to "new growths," tumors of the broad ligament and other pelvic organs, including abscesses, will be found entirely fresh matter. Some changes have been made in that part considering "affections of the ovaries," fallopian tubes and the operation known as oöphorectomy, which of course adds to the material worth of the book. To our gynæcological specialists it must indeed prove a source of gratification to witness the conclusive evidences manifested yearly in the additional character and scientific development of this special department in medicine.

PHIL PORTER.

**DIPHTHERIA : ITS NATURE AND TREATMENT**, by C. E. BILLINGTON, M.D., and **INTUBATION IN CROUP, AND OTHER ACUTE AND CHRONIC FORMS OF STENOSIS OF THE LARYNX**. By JOSEPH O'DWYER, M.D. Octavo. 326 pages. Price, muslin, \$2.50. New York : William Wood & Company.

Perhaps on no one medical subject is there more variance of opinion than on that of Diphtheria. Any work, therefore, which presents the results of a careful revision of the many views held respecting this disease, and in addition offers the fruits of active experience in its study and treatment, has valid claims for the fullest recognition. It is with the greatest pleasure that we avail ourselves of this opportunity for the expression of and judgment of the value of Dr. Billington's work on Diphtheria, and of the chapter in that work on Intubation in Croup, etc., by Dr. O'Dwyer. Turning aside from the reading of so many medical books which are simply old stories in changed form, we take up this work and read it through from cover to cover with the keenest relish. It is a book for the practitioner ; it is none the less a book for the specialist. In a concise, practical manner it carries the reader smoothly, pleasantly and practically through the history of the disease, and etiology, pathology symptoms, complications, diagnosis, prognosis, prophylaxis and treatment. The author disclaims for the work that it is an exhaustive treatise. and yet the reader could not desire for more field to be covered in the consideration of the subject. The preface contains so clearly a statement of the character and scope of the work that the following is quoted :

"I have endeavored to present a clear and succinct statement of those facts in existing knowledge which are most essential to the formation of an intelligent opinion as to its nature, and of those therapeutical principles and details, the comprehension and application of which will, as I believe, enable the physician to treat it most successfully."

That this has been accomplished there can be no question.

The views and conclusions of the author are so identical with

ours that we consume some of our space in presenting a few of them.

He explains that tonsillar diphtheria is least productive of general infection, by the absence in the tonsils of so great an abundance as is the case in other portions of the mouth and pharynx, of blood-vessels and lymph-vessels, the latter of which empty into various glands in the neck and face.

"Croupous" and "diphtheritic" inflammation is not always the result of infection. Local injury to the throat, as from chemical, thermal, and physical agencies may cause membranous laryngitis. The process of pseudo-membranous formation thus resulting is not accompanied with constitutional poisoning, nor is it communicable to others. This is of importance in the consideration of the question whether all cases of membranous croup are cases of diphtheria. The author strongly states that pseudo-membranous croup, in the histological and anatomical sense of the term, is a condition which may be excited by a variety of causes, of which diphtheritic infection is only one. But clinically, simple membranous croup is a non-infectious phlegmasia of the laryngeal or the laryngo-tracheal mucous membrane, the result of the meteorological conditions acting as direct irritants, or, indirectly, by the series of reflexes known as "catching cold." The intensity of the irritation and individual predisposition determine whether these causes give rise to simple catarrhal or croupous inflammation. The records show that there are cases of pseudo-membranous laryngitis not traceable to diphtheritic or other infection.

Membranous croup and diphtheria are two distinct affections. Simple membranous croup is a comparatively rare form of disease. In regions in which diphtheria is endemic or epidemic the two affections are so liable to be inter-complicated or confounded that the distinction is practically valueless.

The chapter on symptoms is remarkably clear. The small, thready, irregular or flickering pulse of diphtheria does not always call for stimulation. The weak action of the heart which it indicates, is frequently due to the causation by the irritated throat of various remote reflex disturbances, including the action of the heart. Constitutional diphtheria, or septic poisoning occurring in this disease, is not due to putrefactive decomposition of diphtheritic membrane, but to septic processes going on *under* the membrane which acts as a covering. The happy division of violent and insidious diphtheria is made. The urine of fifty per cent. of diphtheritic patients contains albuminate some time in the course of the disease, which may, however, be due to existing conditions other than the diphtheria. The presence of albumen is not therefore a diagnostic criterion between diphtheritic and

pseudo-diphtheritic affections, nor is it true that when albumen appears early in the disease that the latter is necessarily a primarily constitutional one. Eruptions in diphtheria are all probably accidental, and have no relationship with the disease.

Chapter VII. is devoted to paralysis following diphtheria. Diphtheritic paralysis is usually a sequela. Its termination, with relatively few exceptions, is in complete recovery. Diphtheritic paralysis is due to the action upon the nervous system of a poison which is the result of the diphtheria.

*Diagnosis* : The one pathognomonic sign of diphtheria is diphtheritic false membrane. The membranous patch of follicular tonsillitis covers the central portion of the convexity of one or both tonsils, and is limited to the tonsils ; while if it is seen on the marginal portion of the tonsillar surface, and is evidently not in relation to the lacunal orifices as its source, it should be carefully investigated, be it however small.

*Prophylaxis* : The observance of the rules and regulations of hygiene greatly protects against diphtheria. The securing of the enactment of proper sanitary regulations in towns and villages, and their faithful enforcement by the authorities, should be regarded as a most important duty by every citizen.

The *treatment* as laid down in this work, cannot in full be accepted by us, except in so far as are concerned the general principles given. We agree with the author in that every case should be treated according to its individuality. The membrane should not be forcibly removed. Loosened portions may be trimmed away with scissors. The agents best adapted for the solution of the membrane are lactic acid, lime-water and other alkalies, pepsin, trypsin and papayotin. Lime-water is not so speedy a solvent as trypsin, but it has the advantages of being a mild astringent, a mild antiseptic, a local sedative and antiphlogistic. Pepsin acts efficiently only in an acid solution. Trypsin is a direct disintegrator and should be preferred for spraying into the larynx in diphtheritic croup. It should be applied in an alkaline medium every ten or fifteen minutes.

Among antiseptics, cleanliness, the salt of mercury, carbolic acid, salicylic acid, chinoline, resorcine, sulphur, chlorine, bromine, iodine, iodoform, chloral, oxygen, benzoate of sodium, chlorate of potassium, borax, oil of turpentine, eucalyptus, hydronaphthol with papain, chloride of iron, quinine and alcohol, are considered. The bichloride of mercury is extolled the most.

The internal medicinal treatment does not, of course, meet in all respects, with our approval.

We would like to have the room to write more than a mere note of the chapters on Tracheotomy and Intubation. They are practical, and leave very little for the imagination of the reader. The

use of tubes in the larynx for various forms of stenosis of the larynx, is clearly set forth. The introduction of the tube is accomplished in ten seconds. Dr. O'Dwyer advises the complete isolation of every case in which there is even a suspicion that pseudo-membrane may be developing in the larynx.

Diphtheritic or fibricous croup without the aid of intubation or tracheotomy proves fatal in from 90 to 95 per cent. of the cases. With their aid 37 per cent. can be cured. Brown gives, as intubation statistics, 2372 cases from 159 operators, with 646 recoveries, or 272 per cent.

G. Y. C.

**THE CONCORDANCE REPERTORY OF THE MORE CHARACTERISTIC SYMPTOMS OF THE MATERIA MEDICA.** By WILLIAM D. GENTRY, M.D. Six Volumes. Vol. I. New York: 1890. A. L. Chatterton & Co. Cloth, \$6.00. Sheep, \$7.00. Half-Morocco, \$7.50. Sold by subscription. Pp. i. to xvi.—1 to 835.

No work in our literature of greater importance than this has been published. Not only can every symptom be found with ease and accuracy, but a month's use of the book has demonstrated repeatedly the fact that the remedies are not only carefully selected, but include the most recent discoveries and teachings, and it is but an hourly occurrence to verify at the bedside the correctness of the compilation.

A more extended review of the work is deferred until the volume bearing specially upon diseases of the female sexual organs is produced.

**PUBLICATIONS OF THE MASSACHUSETTS HOMŒOPATHIC MEDICAL SOCIETY. 1889.**

Our Massachusetts homœopathic physicians have always been strong in their gynæcological tendencies, and we are therefore not surprised to find the greater part of the proceedings of their State Society taken up by the reports of the bureaus of Obstetrics and of Gynæcology.

In the Bureau of Obstetrics a number of interesting clinical cases are reported. Dr. Wesselhoeft discusses the "Management of Posterior Positions of Occiput in Cranial Presentations with Ineffectual Pains," and Dr. Southwick has a paper on the "Treatment of Convulsions during Pregnancy." With regard to this last paper, the author advocates the induction of abortion without delay when, with albuminuria and œdema of the extremities, there appear headache, disturbance of vision, and epigastric pain. That a *continuation* of these symptoms demands abortion is beyond question, but it is often difficult to make a decision on this point without repeated examination of urine and ophthalmo-

scopic examination of the *fundus oculi*. Two years ago\* we called the attention of obstetricians to the importance of ophthalmoscopic examination in the albuminuria of pregnancy, and we now are pleased to find Dr. Southwick also pointing out its value.

The Bureau of Gynæcology contains a discussion of the general, surgical, and electrical treatment of uterine fibroids. The paper on the application of electricity to fibroids contains only a few notes on the methods of various authors; no mention is made of Corlet's thesis, of Torre's thesis, nor of Lawson Tait's reply to Keith's advocacy of electrolysis.

Probably the masterpiece of the Transactions is the "Critical Analysis of Drug-Provings." This article is accompanied by charts containing illustrative examples, and we consider ourselves fortunate indeed to be the possessor of one of Dr. Wesselhoeft's charts. If anything can be accomplished by this method, in the way of sifting out the unreliable symptoms of the innumerable remedies represented as important for gynæcological purposes, we will be pleased to open our pages to "critical analyses" of the sexual symptoms of the most important drugs.

**HYPNOTISM: ITS HISTORY AND PRESENT DEVELOPMENT.** By FREDRIK BJÖRNSTRÖM, M.D. Translated by BARON N PASSE, M.G. Humboldt Publishing Co., 28 Lafayette Place, New York.

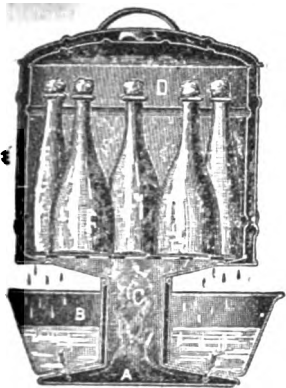
Among the interesting psychological works published lately in the Humboldt Library, this translation of Björnström's brochure is one of the most useful in its relation to gynæcology. Not that we mean in a therapeutical way directly (for we do not believe that the American women are amenable, as a general thing, to treatment by *suggestion*, when in a hypnotic state), but that, in a *mediate* way, a study of this book will lead to surrounding the women who consult us by all the possible precautions that can prevent the influence of those harmful suggestions, which sustain the ideas of the patient that she has this or that disease.

The author takes up the various aspects of hypnotism and passes them in careful review, terminating by a consideration of the misuses and dangers of hypnotism. But of all this, the most useful to us, and the chapter which we regard most highly, is that to which we have referred, "Suggestion." In a limited sense, suggestion plays a far greater rôle in its influence upon hysterical patients than we are inclined to concede, and a careful reading of the author's words upon this subject will well repay the physician who seeks to correct the mental hygiene of an hysterical woman.

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\**Homœopathic Journal of Obstetrics*, vol. ix., p. 553.





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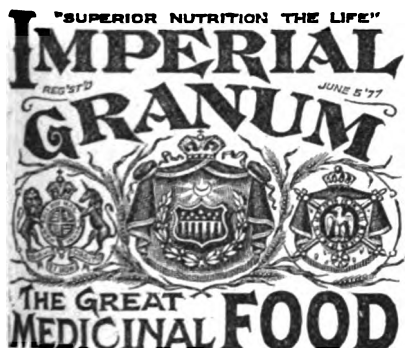
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BY

SHELDON LEAVITT, M.D.

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Within the past year, Dr. T. G. Comstock has twice considered, at some length, certain phases of occipito-posterior positions, and his papers, in both instances, elicited considerable discussion in the societies to which they were presented (the Clinical Society of Hahnemann Hospital, and this American Institute of Homœopathy); the same subject was, I believe, briefly considered by Dr. F. B. Righter, in the *Medical and Surgical Record*, though I cannot now put my hand on the article; Dr. Elias C. Price favored us with a brief article on the subject in the November number of the *Hahnemannian Monthly*; and now Dr. J. N. Mitchell discusses it in the January number of the last-named journal. Perhaps enough has already been said, but the very fact that the subject has been thought worthy of so much attention, pleads sufficient excuse for this paper.

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\* Read before the American Institute of Homœopathy, June, 1890.

In August, 1870, I prepared an article on the subject of "The Forceps in Occipito-Posterior Positions," which was published as the initial article in the first number of the HOMŒOPATHIC JOURNAL OF OBSTETRICS. The opinions which I then held with regard to the matter have suffered no material change, and, in the course of these observations, I shall take the liberty to make some quotations from that paper.

My early obstetrical instruction did not lead me to associate with occipito-posterior positions any remarkable degree of difficulty or danger, either to mother or child; and I had been in practice some little time before I learned that these positions were looked upon by many obstetricians as peculiarly inimical to facile parturition. About that time there came under my eye a paper written by Dr. John S. Parry, and published in the *American Journal of Obstetrics*, some years previously, in which the author strongly advocated, as a method of treatment, introduction of the hand, in the early part of the first stage of labor, and forcible rotation forwards of the occiput. Such treatment impressed me at the time, and still does, as unnecessarily harsh and dangerous. I then believed, as I still do, that, under suitable management in the second stage of labor, the natural forces are enabled, though sometimes at the expense of unusual delay, to rotate the occiput forward to the pubic arch.

I do not hesitate to say that, in a large percentage of cases, without the aid of much manipulation, the occiput will turn slowly, but surely, to the front. I am not ignorant that there are many who seriously question what I so confidently affirm, declaring that rarely, if ever, is this movement of the foetal head in such a manner effected; and, upon such false premises, they proceed to advocate various forms of treatment. In what percentage of cases spontaneous rotation does occur, I am unable to state; but, out of the whole number of such positions which has fallen to me,

I know that a considerable percentage of them have moved in regular and orderly course in the desirable direction. Why my experience has been so unlike that of many others, I cannot positively declare ; but it is possibly found in the special effort which I put forth to maintain firm flexion of the head. Those who have given attention to the mechanism of labor understand the deep significance of this. In some cases I add other manipulation which contributes much to attainment of the desired end. This consists of lateral pressure with the fingers on the temple, and traction toward the forehead by means of the finger in the V of the posterior fontanelle. Yet rarely have these been forcible or long-continued.

In my practice special efforts at rotation are never made until the head has cleared the superior strait, or, in other words, has passed entirely into the pelvic cavity. When we observe the form of the superior strait, it at once becomes evident that the head will be in no condition to effect necessary rotation until it lies free in the pelvic cavity. The clinical sign that such descent has been attained is found in forcible pressure of the head on the pelvic floor. It is the peculiar form of the pelvic cavity which determines rotation of the head, and extensive movement of the head on its vertical axis never takes place before the foetal cranium has accomplished the movement of direct descent.

Dr. Price appears to doubt that Clarke, Burns, and others of more modern times, who declare that rectification of occipito-posterior positions be brought about by use of the fingers alone, ever succeeded in thus accomplishing it. As for me, I have no doubt of it.

Under the conviction that spontaneous rotation forwards of the occiput never takes place, and cannot be effected by means of the fingers, Dr. E. W. Sawyer, a few years since, in a paper read before the American Gynæcological Society, declared himself in favor of the forceps for all such cases, with forcible rotation. He was sharply criticised by a

number of his fellow-members, and among them some who occupy high positions as obstetricians. In a brief subsequent conversation with Dr. Sawyer, I learned that he still adhered to the convictions expressed in his paper, and he declared to me that he had never seen a case in which favorable rotation of the occiput took place in response either to the natural efforts or to ample digital manipulation.

In my article on the use of the forceps in these unfavorable positions, before alluded to, I did not take the position which Dr. Sawyer holds; but designed therein chiefly to give the technique of such operations when they became necessary. Application of the forceps above the superior strait, when the occiput is turned away from the pubes, is not the simple operation of using them at the brim in occipito-anterior positions. The instrument is quite as easily adjusted, but safe delivery is attended with much greater difficulty. In that article I mention, as a preliminary to application of the blades above the brim, my practice of rotating the head by careful manipulation with the fingers of one hand on the inside, and those of the opposite hand on the outside, so as to bring the long cranial diameter into the transverse pelvic diameter. That this can in many cases be done without violence, experience has unmistakably taught me. "When there exists a demand for this instrument above the brim," I say in that article, "with the occiput looking more or less backwards, I believe it to be the operator's duty to endeavor carefully to rotate the head, so that its long diameter will coincide with the transverse of the pelvis, before applying the instrument. By virtue of such a change he is enabled, with the forceps in the sides of the pelvis, to grasp the head over the poles of its long diameter, and effectually prevent a backward movement of the occiput, while, if requisite, he can enforce proper rotation. On the contrary, when the instrument is so applied without preliminary rotation, the head is seized in one of its oblique diameters, as has already been shown, and



even slight compression disposes the occiput to rotate into the hollow of the sacrum. The change is so easily accomplished in suitable cases, that explicit directions are not required. The head, as felt in the hypogastrium, should be pressed backwards, while the occiput should be drawn forwards with the fingers of the other hand. Having effected an alteration, the acquired position should be maintained by firm and equable pressure in the supra-pubic space, until the forceps have been adjusted to the head. In default of so doing, it is very liable to revert to the original position."

After having adjusted the forceps to the head in its new position, with one blade over the face and the other over the occiput, I can give no better instruction than that contained in the same article, and which is here transcribed: "When once the instrument is fairly adjusted, if the head is found to be unfixed in the brim, it may be gently raised, and carefully rotated from an oblique or transverse diameter, into a diameter which will bring the occiput forwards; but the operator should beware of violence. If such a movement is not practicable, the head should be drawn, with usual precautions, to the pelvic floor, and then, if the natural efforts are defective, the desirable evolutions can be enforced."

As stated in the same connection, I have sometimes succeeded in varying the usual pelvic mode of application to the extent of getting the blades over the long diameter of the head which lies in an oblique diameter of the pelvis. When this is done, the same purpose is effected as in the method last described.

When it becomes advisable to use the forceps in the pelvic cavity, with the occiput still looking backwards, toward the right or left, a short, straight instrument is the more desirable one, since with it rotation can be completed without the removal and re-application which are required when the long instrument, with pelvic curve, is employed. But it happens that very few general practitioners are provided

with straight forceps, and, therefore, the long instrument, with pelvic curve, became the only alternative. The first application should be to the sides of the foetal head, but with the concavity of the instrument looking toward the child's forehead, for the simple reason that application with that part turned toward the occiput would necessitate a dangerous inversion of the blades.

During slight traction, rotation may be enforced—slowly, gently,—as far as the transverse diameter, and no farther. Removing the blades, they are reapplied, with the concavity of the instrumental curve addressed to the occiput, when the movement may be easily completed. Force is rarely or never required; and if rotation is effected in full recollection of the curves of the instrument and parturient canal, the handles will be given a direction effectually preventing their points from lacerating or contusing the pelvic tissues. I have performed this operation in a number of instances, and have never discovered any serious lesion attributable to it. I am not sure that it is an operation to be undertaken by one unaccustomed to using the forceps, as awkward maneuvers may result in great harm.

Application of the blades over the poles of the long diameter of the head in the pelvic cavity, especially in those instances where the labor is close, is a matter of no little difficulty, and it is on this account that I usually prefer rather than attempt it to make the double application. The bearing is on the pelvic structures, crowded as they are against the pelvic walls; and to make a strenuous effort to push the blades in between the opposed surfaces, is in general unwise, because dangerous. Still, in exceptional instances it can be done, and then rotation can be fully accomplished with the single application; but, for safety to the perineum and vestibule, it necessitates removal of the blades before the head passes the vulva.

The foregoing is a delineation of the methods of using the forceps in these difficult cases, whenever a demand for

interference exists; but what constitutes a demand is not so easily settled. For my own part I look upon the following as indications for interference: (1) Failure of the natural efforts to begin rotation at the proper time and in the proper direction, and (2) inefficiency of careful attention to firm flexion of the head and forward solicitation of the occiput by the fingers. It will be understood that this is applicable to the complication as it is met in the second stage of labor; but occasionally we are called upon to deliver from the pelvic brim, or above. In the latter instance the conditions demanding interference do not materially differ from those which exist in cases uncomplicated by backward position of the occiput.

As I have before intimated, the backward position of the occiput alone rarely constitutes, in well-managed cases, a demand for resort to any operation. In this connection I am glad to see that Dr. Price, after thinking otherwise for many years, has finally been led to believe that even introduction of the hand for purposes of rotation is rarely necessary. Introduction of the half-hand, as now proposed by him, is not seriously objectionable, provided digital aid prove unavailing. I was still farther gratified of late to receive a letter from the worthy chairman of this bureau, in which he says: "From what I have seen, I have come to the conclusion that about the best treatment is, to resist the descent of the forehead, which is simply increasing flexion, by which means we are making way for the descent and anterior rotation of the occiput." "As a result of these studies," says Dr. Mitchell, "and from the fact that rotation occurs spontaneously forward in such a large proportion of cases, and from the fact that even when it does occur posteriorly yet it is possible, in a large proportion of cases, to deliver with safety to mother and child, and from the weight of authority that teaches that though slow in evolution, yet nature can accomplish the rotation, and from my own experience in the conduct of such labors, I am unwilling to accept the teach-

ing of those who advise early interference by operations which are not themselves free from danger to both mother and child. The difficulty of passing the hand into the vagina, already overcrowded with the foetal head, and the possibility of damage from such an overstretching, is as great and greater than from the diameter that would have to pass should the occiput rotate backward, and to attempt such a manipulation before nature has proven her inability, or before the head has reached the floor of the perineum, is unjustifiable, since nature fails so seldom if left alone."

What I have thus far said has no direct bearing on that phase of the subject considered by Dr. Comstock in his excellent contributions. The cases which formed a text for his suggestions were those of occipito-posterior positions not seen by him in the early stages of labor, but which were found by him with the head immovably held at the pelvic outlet. Of course the only form of treatment then applicable was *delivery force*. This was accomplished by him, but at the expense of considerable perineal laceration. Dr. Comstock's present opinion is that management of such cases should include episiotomy, which consists in making latero-posterior incisions into the perineum, with knife or scissors, of sufficient depth to afford the requisite circumferential measurement of the vulva, in order to avoid extensive laceration of the perineum, so sure to occur, in such cases, as the result of the large cranial diameters brought to bear in this awkward position. Though the advocacy of episiotomy has aroused some opposition, I do not hesitate to say that I am quite in accord with Dr. Comstock. This advocacy of episiotomy for certain rare cases of occipito-posterior position should not be misconstrued, however, to cover all cases. The operation may be indicated in any position, but is more likely to be demanded when the occiput looks to the perineum, because of the greatly increased circumferential requirement of the vulvar opening. Finally, we are to bear in mind that not all cases of the kind which has

called forth these papers prove remarkably difficult and dangerous, even though they thus terminate, for, in at least two instances, I have delivered, under these circumstances, with neither laceration nor incision. The cases related by Dr. Comstock were exceptionally difficult.

The conclusions at which I have arrived are as follows :

1. Introduction of the hand and forcible rotation forward of occiput are necessarily harsh and dangerous.

2. Nature accomplishes proper rotation in a large percentage of cases ; and when she fails, digital aid is usually adequate.

3. Digital rotation should not be attempted until the head is pressing on the pelvic floor.

4. When the forceps are called for, with the head above the brim, in an occipito-posterior position, the head can sometimes be turned, by manipulation (the fingers of one hand in the vagina, and the other hand on the hypogastrium), so that its long diameter is made to coincide with the transverse of the pelvis, and then by a single application of the blades, in the pelvic mode, delivery can be accomplished with the occiput looking to the pubic arch, but the forceps should be removed before the head passes the vulva.

5. Where preliminary manual rotation cannot be performed with ease, a double application of the forceps is required in order properly to deliver.

6. When the head lies in the pelvic cavity, with the occiput looking back, two applications are nearly always required to effect proper delivery. The exception is found in the instance of relatively small head.

7. Indications for use of the forceps are found in (1) failure of the head to rotate at the proper time and in the proper direction ; and especially (2) failure of the digital, and, perhaps, of the half-hand effort.

8. Episiotomy may be required in any position, but more especially in persistent occipito-posterior positions.

## LEUCORRHŒA, AND ITS HOMŒOPATHIC TREATMENT. \*

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BY

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The term leucorrhœa signifies a more or less abundant discharge of a white, yellowish or greenish mucus from the genital organs of the female.

This discharge may consist of mucus or it may be much thicker and of a creamy consistency. Sometimes it is viscid, stringy, and tenacious, and even purulent. It thus presents all the variations from simple healthy mucus only increased in quantity up to pus secreted from an ulcerated surface. In quantity the discharge varies from the very slightest increase in the amount naturally secreted by the glands of the mucous membrane up to several ounces in twenty-four hours. This flow is, in some cases, bland and unirritating, while at other times it becomes very acrid and corroding, denuding the mucous membrane wherever it comes in contact with it. It often from these irritating qualities gives rise to a severe and very intractable form of pruritis. In this acrid form the leucorrhœa has often been known to give rise to a discharge from the male genital organs, from sexual intercourse, closely resembling gonorrhœa.

From this cause innocent women have been accused of infidelity by their husbands.

It is very difficult to diagnose such cases even in the female from a genuine attack of gonorrhœa.

In an acute attack of leucorrhœa we find all the symptoms of inflammatory action, consisting of pain, heat, and redness of the parts involved. After a few days and as soon as the flow becomes abundant, these inflammatory

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symptoms subside to some extent. There is drawing, dragging pain in the loins and small of the back; in the inguinal region and down the thighs, accompanied by heaviness in the pelvis, also dysuria and tenesmus. Acute attacks are characterized by more or less fever and tenderness of the lower part of the abdomen.

Chronic cases of leucorrhœa present innumerable morbid symptoms as well as a great variety of causes, and present every possible variation in severity. It is often difficult for the patient to tell you when the attack began, as in many cases there has been more or less discharge for many years, and it is only when it begins to impair the health and break down the system that they give heed to their trouble or ask the aid of the physician in obtaining relief from this often very troublesome disorder. We usually find this discharge the most troublesome just before and just after mēstruation, and sooner or later we begin to observe menstrual irregularities, and this discharge more and more encroaching upon, and taking the place of, the normal menstrual flux, until in some cases it entirely supplants or takes the place of that discharge.

This menstrual irregularity, if not directly caused by the leucorrhœa, is so indirectly by lowering the tone of the system and bringing about a condition of chronic debility, whereby the generative organs are no longer able to properly perform their functions.

In like manner the appetite fails and the digestive organs become enfeebled, resulting in inveterate costiveness and general nervous debility. The mental as well as the physical being suffers, and the natural buoyancy and cheerfulness of disposition is replaced by irritability and fretfulness, or even settled melancholy. Thus a long train of symptoms may result from the debilitating effects of this leucorrhœal discharge upon the system, varying in kind, degree, and intensity, according to the soil upon which this disease has been

engrafted. The longer the leucorrhœa exists the more it changes the mucous lining of the genital organs.

In chronic cases the mucous membrane becomes thickened and hypertrophied, and sometimes studded with polypous excrescences and turns brownish or slate colored. We also find erosions usually on the posterior lip of the cervix, which are caused by the swelling, bursting, and suppuration of the ovula Nabothi.

The what might be called exciting causes of leucorrhœa are almost anything that will cause stagnation or in any way interfere with the proper circulation of the blood, such as heart and lung diseases, constipation, pessaries, masturbation, and sexual excesses. Also some infectious diseases, such as small-pox, cholera, scarlatina, measles, typhus, etc. Exposure to cold and dampness caused by being too thinly clad, or sitting upon the ground or stone steps, may cause an acute attack, as well as violence of any kind that is capable of producing irritation and inflammation of the mucous membrane lining the genital tract.

Leucorrhœa is frequently one of the sequelæ of parturition and especially abortions and miscarriages, as well as at times being developed by the irritation and congestion of the regular menstrual period. Living in houses where the walls are damp, or where the living rooms are situated over the cellar containing water, or where the house is in a very marshy district, has been mentioned as among the causes leading to a catarrh of the genital organs. Another entirely opposite condition of living may give rise to this trouble, namely, too high living and a too free indulgence in stimulating beverages, spices, and stimulating articles of food, generally combined with indolent and sedentary habits of living.

Acute leucorrhœa may sometimes be critical and even salutary, affording a means of escape to an excess of serum that has accumulated within and about the glandular structure of the cervix uteri. It seems to be designed to open a



safety-valve and thus prevent local congestion and inflammation as well as to prevent trouble in more remote organs, giving relief to an attack of bronchitis, indigestion, or sick headache. It may eliminate products that if retained would prove injurious to the system.

Irritation of the mammary glands and especially of the ovaries often causes and serves to keep up a leucorrhœal discharge that it is impossible to cure permanently until the ovarian trouble which is the real cause of the leucorrhœa is cured. The use of local applications, and astringent washes of all kinds, particularly in cases of this character, are productive of evil, and not only do not cure the case but really increase the trouble by sealing up this salutary discharge.

I have mentioned many of what might be called the exciting causes of leucorrhœa, but back of all the exciting causes stands the predisposing cause of leucorrhœa, which is but another name for psoric diathesis or scrofulosis.

Here lies the whole secret, which tells us clearly and fully why some cases become chronic, while others get well without any care or treatment at all. Unless there was a scrofulous or psoric taint in the system it would be utterly impossible for any case of leucorrhœa to exist but for a very short time, because the natural powers of the perfectly healthy human body would, in a very short time, eradicate it without medication of any sort or kind. Unless we fully grasp the importance of this fact and thoroughly understand the power and workings of this psoric or scrofulous predisposition, we will utterly fail in properly comprehending our cases, and be completely baffled in our attempts to cure them.

The ability to properly grasp and comprehend the full meaning of this diathesis is the key to our success in the treatment of all the diseases that flesh is heir to, but especially those of the skin and mucous membranes. Those physicians that study the Organon of Hahnemann the clos-

est, and become able to comprehend this fact the most perfectly, are the ones that make the greatest successes in life, and we call them lucky, but the real reason is, they can cure the cases that others who fail to practice or comprehend this fact are utterly unable to do.

The psoric or scrofulous taint in the system tends to develop itself either upon the skin or mucous membrane according to its original nature.

We often find a strongly manifested hereditary tendency to leucorrhœa in certain females, it having existed for several succeeding generations in their family, as well as other scrofulous troubles, such as consumption, cancer, and anæmic troubles generally.

*Treatment.*—In the treatment of leucorrhœa we must endeavor to find out the exciting cause of the trouble so far as possible, and remove that cause no matter what it may be.

If the patient be badly nourished, we must endeavor to build her up by a good nourishing diet, such as steak, eggs, milk, etc.

If her strength is being impaired by over-lactation, if possible have the baby weaned, and thus place her in a condition to improve in health and strength, and in proportion as she gains in strength her leucorrhœa will improve.

If you find a case of chronic ovaritis of one or both ovaries, your efforts should be directed to cure that trouble before you can ever hope to cure the discharge.

The same may be said of chronic endometritis, as well as all other causes of irritation affecting the female genital organs. Always prescribe for the patient and never for the name of this or any other disease, bearing in mind any possible hereditary weakness.

Every case, if closely studied, will be found to possess a peculiar and particular history of its own, which, if carefully considered, will prove an unerring guide in the selection of the curative remedy or remedies. In all chronic cases,

at least, we must pay particular attention to the diathesis, and make our selection of remedies from the long list of anti-psorics that are alone able to remove this psoric or scrofulous taint from the system and cure the case.

Cleanliness should never be lost sight of in the treatment of these cases, and the free use of hot vaginal injections will be salutary and helpful.

I will give some of the indications for a few of the leading remedies in leucorrhœa, but would refer you to the *Materia Medica* and different works of practice for the study of any particular case.

*Æsculus hip.*—Leucorrhœa with lameness across the back, so that walking is difficult; constipation, hæmorrhoidal troubles, feeling as if there were sticks in the rectum.

*Alumina.*—Profuse yellow, acrid, corroding discharge, burning of the genitals; very profuse acrid discharge worse in day-time; worse before and after menses, running down to heels in large quantities; constipation, with inactivity of the rectum; leucorrhœa relieved by bathing in cold water.

*Ambra grisea.*—Leucorrhœa, only at night; bluish-white mucus, stitches in the vagina before the discharge.

*Belladonna.*—Leucorrhœa with colicky pains appearing suddenly and as suddenly vanishing; bearing-down pains, as if the womb would push out; tenderness of the abdomen.

*Borax.*—Leucorrhœa midway between the menstrual terms; sensation as though warm water were flowing down; nervousness; cannot bear a downward motion or horseback riding.

*Bovista.*—Leucorrhœa after the menses flowing only at night; thick, slimy, tenacious, acrid and corrosive.

*Calcarea carb.*—Profuse milk-like discharge with soreness and swelling of the vulva; too early and too profuse menses; scrofulous subjects, very sensitive to cold; damp feet, as though she had on damp stockings; leucorrhœa of children.

*Cantharis.*—Discharge of bloody mucus after urinating;

frequent urging to urinate, with cutting and burning; increased sexual desire; gonorrhœa.

*Carbo veg.*—Great foulness of all secretions; discharges very acrid, excoriating the parts; itching of the genitals; flatulency; soreness and rawness of the external genitals.

*China.*—Leucorrhœa before the menses; great debility; bloody leucorrhœa with occasional discharges of black, foetid, purulent matter.

*Cocculus.*—Scanty, irregular menses, or leucorrhœa instead of menses; great sense of prostration and weakness.

*Collinsonia.*—Leucorrhœa with pruritis, and obstinate constipation.

*Conium mac.*—One of the best remedies in indurations, especially of a scrofulous nature or from injuries; prolapsus uteri complicated with induration, ulceration and profuse leucorrhœa.

*Kreosote.*—Leucorrhœa smelling like green corn; mild and painless as well as putrid, acrid and corroding leucorrhœa, often indicated for old ladies and young girls.

*Graphites.*—Profuse leucorrhœa, day and night, with great weakness of the small of the back; skin irritable, ulcerating easily; constipation, stools large and knotty.

*Helonias.*—Leucorrhœa with anæmia and general torpid condition of the system; prolapsus uteri; adapted to women worn out with hard work, whose strained muscles burn and ache; relief from being actively employed; consciousness of a womb.

*Hydrastis.*—Yellow leucorrhœa of a very tenacious character, hanging from the os in long, viscid strings.

*Kali bich.*—Yellow, ropy, tough leucorrhœa, can be drawn out in long strings.

*Lachesis.*—Leucorrhœa from three to eight days before the menses; copious, smarting, slimy, stiffening the linen and staining it green; cannot bear any pressure, not even the clothing upon the uterine region.

*Lycopodium.*—Leucorrhœa accompanied by a cutting

pain across the hypogastrium from right to left; red, sandy sediment in the urine, resembling brick-dust.

*Mercurius sol.*—Leucorrhœa worse at night, itching, burning and smarting; scorbutic gums and enlarged tonsils; leucorrhœa purulent in character.

*Natrum mur.*—Acrid, green leucorrhœa, especially when walking, pimples on the mons veneris; chlorotic, cachectic patients with sallow skin; palpitation, oppression of the chest, delayed and scanty menses with headache.

*Nitric acid.*—Leucorrhœa consisting of flesh-colored mucus, syphilitic ulcerations; brown urine, strong fœtid odor; pruritis, with stitches in the vagina.

*Nux moschata.*—Leucorrhœa of women who always awoken with a very dry tongue.

*Nux vomica.*—Fœtid leucorrhœa tinting the linen yellow, backache, frequent ineffectual efforts to stool; patients that have been drugged.

*Phosphorus.*—Smarting leucorrhœa drawing blisters; suitable to tall and slender persons with phthisical habits.

*Phosphoric acid.*—Leucorrhœa after the menses; great sense of weakness with a remarkable state of indifference; passes large quantities of colorless urine.

*Pulsatilla.*—Thin, acrid leucorrhœa, or thick white mucus; menses too late and scanty with abdominal cramps; flat, nasty taste; symptoms worse in the evening; relieved in the open air; mild, yielding, tearful disposition.

*Psorinum.*—All excretions, leucorrhœa, menstrual flow, perspiration, eructations, have a carrion-like odor. Especially adapted to the psoric diathesis; in chronic cases when well-selected remedies fail to improve; debility with lack of reaction after severe acute diseases.

*Sabina.*—Yellowish, corrosive leucorrhœa making the thighs sore, causing intense itching; during pregnancy and after delivery; painful active congestion of uterus.

*Secale cor.*—Leucorrhœa of thin, scrawny women, with prolapsus uteri; subject to passive hæmorrhages; tendency to gangrenous mortification.

*Sepia*.—Suitable to feeble and debilitated women of a dark complexion; yellow saddle across the nose; milky leucorrhœa, only in the daytime; sudor hystericus; peculiar fœtid perspiration, particularly from genital organs, axilla, and soles of the feet; fœtid, putrid urine depositing a yellow clay-colored sediment, adhering to the bottom and sides of the vessel; sensation as if everything would press out of the vagina, having to cross her legs to prevent it. Painful sensation of emptiness and goneness in the pit of the stomach.

*Stannum*.—Leucorrhœa with marked loss of strength; the weakness seeming to proceed from the center of the chest; menses too early and too profuse.

*Sulphur*.—Leucorrhœa smarting like salt; scanty, acrid; leucorrhœa causing soreness of the vulva; constipation; diarrhœa, driving the patient out of bed in the morning; burning of the soles of the feet; heat on top of the head; stoop-shouldered, cannot walk erect.

*Thuja*.—Cancer and scirrhous of uterus; wart-shaped excrescences at orifice of the uterus; fig warts all over the genitals.

*Zincum*.—Leucorrhœa consequent upon masturbation and attended with great nervous exhaustion; restlessness of feet, she cannot keep them still. Chronic and excessively violent and obstinate headache.

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## COMMONPLACE MIDWIFERY.

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BY

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(Concluded from page 251.)

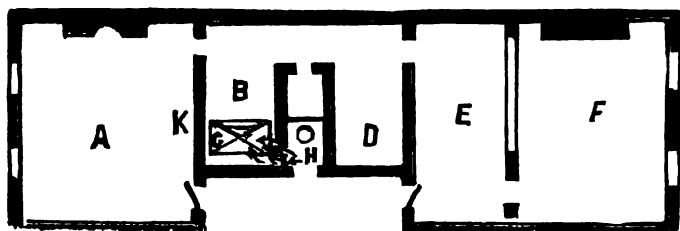
**PUERPERAL FEVER.**—*In re* puerperal fever I have had two cases of my own, and have seen others in consultation.

I distinguish here broadly between fever simply occurring during the puerperium, and fever due to septic influence. Both my cases were the result of sewer-gas infection, which I believe in cities is a frequent cause of this alarming condition. The attention of the profession was directed to sewer-gas as a cause of puerperal fever by Prof. Playfair,<sup>28</sup> about three years ago. Shortly after this, while the *Lancet* article was still fresh in my mind, I was called to a case which proved, before I was done with it, one of the most annoying in all my obstetrical experience. The woman, 1-para, was unusually healthy and robust; the labor lasted from 3 o'clock A. M., to 10 A. M., which was not over long for a 1-para, and was normal in all respects. The case progressed favorably without any untoward symptoms until the tenth day, when on calling, as I supposed for the last time, I found her suffering from rheumatoid pains about the hips and in the right wrist and ankle joints. There was not much fever, 100.5° Fahr., but considerable restlessness and sleeplessness, and I had noticed for several days a lowness of spirits, which, however, I had assigned to family reasons. The restlessness, sleeplessness, and apprehensiveness led me naturally to *cimicifuga* as the remedy, which I gave in the sixth decimal potency. The next day she seemed better, and as I was anxious to go out of town, and as she did not seem desirous for my continued attendance, I left her sufficient medicine to last some days, and departed. I heard no more of the case for two months, when, being in the neighborhood, I called to see how mother and child were faring. To my amazement and chagrin I found she was as yet barely able to sit up, and bore every evidence of a severe illness. It would seem that the good effects which apparently followed the administration of *cimicifuga* lasted but a day or two, when the pains increasing in severity the husband, who was a policeman, called in the precinct surgeon.

<sup>28</sup> "Defective Sanitation as a Cause of Puerperal Diseases," by W. S. Playfair, M.D., LL.D., in *Lancet*, Feb. 5, 1887.

He treated the case for some days, and then called in consultation a well-known specialist, who, of course, when he learned that I had been in attendance, pronounced it a case of malpractice ; said that the whole trouble was due to a piece of the after-birth which had been left in the womb ; and was absolutely horrified when he learned that the case had been conducted, from beginning to end, without the paraphernalia of carbolic antiseptics. That a portion of the placenta, or any of its membranes, had been retained within the uterus, I knew to be impossible ; first, because I make too careful an examination of the secundines to be readily deceived, and secondly, because the lochia had been normal throughout, in complexion and odor, though perhaps rather scanty for so robust a young woman.

The patient had remained all this time in an inner room, as per the annexed plan ; in which A, is the sitting-room ;



B, the room in which the patient was confined ; D, another bedroom ; E, dining-room ; and F, kitchen. Upon removing the bed at C, I found that the baseboard at I had sprung so that there was a space between it and the floor of nearly an inch, and beneath this an opening of half an inch or more between the flooring boards, so that the gases from an imperfectly working water-closet trap passed directly upward over the patient's bed.

As the progress of the case had been so unsatisfactory under the champion of antiseptics I was rather grudgingly asked to resume the conduct of it, which I did ; removing the bed to the point K, in room A, and closing room B



entirely. With this change, and under the arseniate of cinchona, 3 and 6, the patient gained rapidly, and at the end of the then current month removed, on my advice, to new apartments. But for my fortunate social call, and the consequent discovery of the real source of the fever, my reputation in that family would have been very low indeed. In fact, I never was forgiven, so strong was the impression that somehow the lingering convalescence was to my discredit, and although I had had all the work of the family connection—six separate households—for seven or eight years, and had had nine babies, I have never been called since.

My other case of puerperal fever was some two years earlier, and although I knew the drains were bad, I did not ascribe the fever to that cause, at the time. The case got well; I cannot justly claim to have cured it.

ECTOPIC PREGNANCY.—The scholarly paper read by Dr. Ostrom at the last meeting of this society,<sup>29</sup> and the discussion which ensued, and especially the case reported so lucidly and interestingly by Professors Danforth and Doughty,<sup>30</sup> would have led me to ask if the usual hour for adjournment had not already long past. Has homœopathy anything to say to these cases? I do not ask this in a critical spirit, but as one who is groping in the dark. I can understand the fascination of surgical work, and the necessity for it; I can understand also the all but irresistible pressure of professional bias in favor of dealing with such cases with the knife, all the more irresistible because so unconscious; and I can understand how by so doing one at least escapes the censure which certainly follows when medical treatment proves as unavailing to save life as surgery frequently does; and, then, it is always so comfortable to be in with the majority. But there are some members of this society who study *materia medica* as others do surgery, and it is to them I put the question; I do not know the answer.

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<sup>29</sup> Published

<sup>30</sup> *Vide.*

Some six years ago I had a case which I stumbled over in a manner which makes me blush when I think of it ; but the woman is alive and well. Was it my ignorance or stupidity that saved her? The one Dr. Danforth treated is dead ; and no one will doubt that that case was treated with consummate ability, and with ripe knowledge of the science of the day.

The question between *materia medica* and surgery is not personal but generic ; it has been asked by Carroll Dunham, by Constantine Hering, by Henry S. Guernsey, by all the great names in homœopathy ; it is one which never can be answered as a finality until some day when we have a homœopathic Darwin ; nevertheless it behoves us to ask the question, and earnestly to seek the answer, for even a Darwin can only construct with what has been gathered together by predecessors in the field of observation.

The case to which I have referred was this : On August 13, 1883, about two o'clock in the afternoon, I was summoned to see a lady on Forty-third Street, under the following circumstances : She lived in an apartment house, and had gone into the cellar to look over some trunks, and was found there, in an unconscious condition, by the janitor, and carried into his sitting-room in the front basement ; and he, knowing that I was the family physician, sent one of his children to my office. The patient was about twenty-eight years old, had been married some six or seven years, had had one child, since dead. She was of the English type, large and robust, and prided in her physical endurance. I found her comatose, extremities and indeed the entire surface of the body cold, pulse slow and feeble, face natural in expression, pupils slightly dilate. The weather was sultry, and I at first supposed I had to do with the mingled effects of heat and alcohol, as she was a dipsomaniac, though a lady by birth and education, and both the daughter and wife of professional men. She drank only at long intervals, but would when the fit seized her consume a quart

of whisky at a single sitting, and would then appear to the ordinary observer none the worse for it. I never knew a man who could carry a load of whisky as easily as this woman could, and I doubt if a half-dozen people in the world had ever discovered her failing. Whether she really had had anything of that nature on this day I never knew, as they had poured some brandy into her throat before my arrival, and thus confused the diagnosis; she always denied afterwards having had anything, but she always did deny. However, I gave her some *nux vomica*, first decimal, to antidote any free alcohol there might be in the circulation, and applied friction and hot flannels to the surface to induce reaction. This having no very apparent effect after several hours, I then gave belladonna 200. The skin gradually assumed a natural feeling and temperature; she could be aroused by not over-gentle shaking, but at once relapsed into a stupor. This continued for a week, when she gradually became less and less difficult to maintain in a conscious state, though for fifteen or sixteen days she would drowse off if left alone. After the first week, while asleep she would maintain long conversations with imaginary friends, especially with an officer in the army who had been an intimate friend of the family for many years, and these conversations could be directed to any topic by simulating the voice of the person she believed was present. This was a very interesting phase of the case. There were others that were not so. The natural functions of the body were performed scantily but automatically. No food could be taken, even a few teaspoonsfuls of milk or beef tea would cause frightful retching. The only thing she could retain was champagne, and this had to be fed by the teaspoonful. There was also a tendency to spasmodic movement of the muscles of the face, of the fingers, and of the toes. All these things led me to fear an attack of apoplexia.

After sixteen days the condition of things was about like this; The patient as she lay in bed presented no abnormal

appearance when asleep; during these somniloquies she would seem to be merely talking with her eyelids shut. But when awake she was despondent, certain she was going to die, but apathetic as to living. She made her will and bid good-by to her friends. Muscular power did not seem wanting when she chose to exert it, but her hands trembled so that she could not hold anything; even the signature to her will was indistinct, though her natural chirography was bold and good. Though the rest of the skin was normal in appearance and temperature, her nose was cold all the time; not pinched as in a patient's with a chill, but like a healthy person who has been out in the frosty air. There seemed to be a complete loss of both the sense of taste and of appetite, with difficulty in swallowing any solid. All sorts of little dainties were prepared for her, but with the exception of ices and ice-cream she could take none. Even the sight of solid food caused nausea, and when we compelled her to take some it was followed by faintness, and the vomiting of thick slime. The bowels did not move, or but scantily, and urine was passed involuntarily during the somnolent period. She had had some years before (1877-1878), following small-pox, a rupioid eruption on the scalp, which was cured by apis. Now some of these old cicatrices reopened and began discharging a thick creamy pus; these sores were fistulous with hard, bluish-red edges. During a somniloquy she had spoken of herself as being pregnant; speaking of it then as that there were to be two deaths in one; and this she admitted afterwards in the waking state. She had had the May period all right, but in June the menses did not appear; according to this she was now pregnant thirteen or fourteen weeks. The janitor's wife, when we undressed her, on the day she was taken ill, remarked that she looked as if she were in the family way, and I noticed that the abdomen was distended and hard; though this could hardly have been due to an ordinary pregnancy of eleven or twelve weeks. If, however, there

had been hæmorrhage into the tube from a ruptured tubal foetal cyst, and the blood retained by a blocking up of the tube, the abdominal hardness might be accounted for, as well as the collapsed state in which she was found. Certainly there had been no vaginal discharge up to this time.

I believed that the belladonna had held the case in check, and prevented intercranial effusion; and now after a lapse of six years, with every desire to know the truth and to speak the truth, I still feel that belladonna saved her life during that critical fortnight. There are many little events that float as it were on the surface of such an epoch, too elusive to state intelligibly on paper, but which do, however, produce distinct impressions on the watchful practitioner's mind, impressions no less powerful in settling opinion because thus subtle, and in this way I sensed rather than proved the value of belladonna at this time. We all, I think, have in cases that arouse our intense interest an inward feeling, too elusive to be called a thought, as to how a case is going, whether for us or against us. I have heard of doctors who have declared the patient doing well, and stepped into the next room to make a prescription, and were summoned back to see the patient die in five minutes, but this can only be accounted for by crass inattention.

But now, after sixteen days, as belladonna seemed to be accomplishing very little, although I had given it a fair trial in varying potencies (200, 12, 30, 6) I concluded to give silicea, and for this reason: The patient suddenly and from no known cause is taken seriously ill after years of fine health. Either, therefore, the cause is a deep-seated one, or else she had somehow come under the influence of some powerful inhibitory force. This latter did not seem reasonable, as there was no evolution of symptoms; these had not changed in nature during the period she had been under observation, nor did she seem like one under septic influence. It appeared probable that we had to do with a deep-seated organic discord which required a tissue remedy to

uproot. There was, it is true, no such distinct call for silica as would warrant the assertion that in it, and it only, we had the true homœopathic indication fulfilled. Silica has the following symptoms :

Gloomy, feels as if she would die.

Desponding, melancholy, tired of life.

Apathetic, faint-hearted.

Eruption on occiput ; moist, offensive, burning, itching, discharging pus.

Cold nose.

Loss of taste and appetite, with difficult swallowing.

Nausea to fainting.

Vomiting of tenacious mucus.

Involuntary micturition.

Trembling of the hands.

Somnambulism.

Silica was given in the 200th potency (Carroll Dunham's), a few pellets, dry on the tongue, daily at noon. In less than a week there was a marked change for the better ; the somnolence gradually disappeared ; the mental equipoise was restored ; appetite returned ; the functions were performed naturally ; the ulcers on the scalp healed : and before the end of September she went into the country for a brief change of air, in well-advanced convalescence.

I now looked forward to no further trouble with the case, save such as might arise through the advancing epoch of pregnancy ; but on November 5, I was summoned on account of a sudden and copious hæmorrhage from the uterus. She had lost a great deal of blood, perhaps a pound, and was very much prostrated, but the flow ceased before my arrival. She had felt severe cramping pains, and had gone to the water-closet, and most of the loss had taken place there. I had a few two-grain bi-sulphate of quinia pills in my pocket, and gave her one of these every five minutes until she had had six. I was afraid to give aromatic spirits of ammonia because of its liquifying influence on the blood,

and I feared further hæmorrhage. After waiting an hour, and no untoward symptom arising, I left some cinchona 6, and departed. I was back and forth a number of times, but she had no more bleeding, and in a few days recovered from the prostration. In making an examination I found the os soft and swollen, and the whole condition of things not like what we ordinarily find at the end of pregnancy. I suspected placenta prævia. As, however, there was no further hæmorrhage I did not feel justified in suggesting operative interference, as there was hope, at least, for a living child.

At the end of the seventh month, January 11, 1884, there was a similar hæmorrhage, not quite so copious nor so sudden, and as it had not stopped when I arrived at the house I gave trillium 3, and packed the vagina with lint soaked in liquor ferri subsulphatis. This seemed to cause an intense burning sensation, and was removed; leaving behind it an acrid leucorrhœa which lasted several days. She was in a low state of health during the next two months, with pains and aches, depression of spirits, but with no special indication of disaster to come. On March 6 she was taken with labor pains, and I was summoned about two o'clock. An examination revealed a strange state of things. The uterus was about the size usual at the fifth month, but behind and above and to the left of it was a tumor much larger than the uterus, and fluctuant. This I, of course, ought to have discovered earlier, but the marked disinclination of the patient to physical examination had deterred me from insistence. The pains were regularly intermittent, and seemed to involve both the uterus and the tumor, so much so that I was in doubt whether we had not a bicornal uterus to deal with. The cervix was soft and dilatable, and there was an insignificant bleeding just enough to worry me. I have a constitutional dislike to throwing off responsibility. I had much rather fight my way through any difficulty than to ask assistance, and when I no longer feel competent to

manage a case would rather give it up entirely, than to share responsibility with a consultant. In fact I almost never ask for help in that way. I did now suggest sending for Dr. Helmuth, but the patient objected, and as there seemed no immediate danger, and the pains were not severe, I waited. The pains gradually died out, the patient went to sleep. The next day the pains returned with more force, and I now desired to administer an anæsthetic and make a thorough examination. But the patient was willful and would not have it, and I finally got angry and threw up the case, advising her to call somebody she would be guided by. The relation which had existed between the family and myself had been cordial and of long-standing, and I believed that a stranger might do better for her; evidently my authority and usefulness was at an end. But the next day I went to the house to see how she fared. Nothing special happened. The pains died out gradually and did not return. She had irregular hæmorrhages, but none of moment, and these gradually grew less and less in quantity and frequency; but in the course of a year she completely recovered health, and is now as robust and vigorous as any one need wish to be; though the monthly period has never been resumed. I have never treated her since, and understand she has had none. She is now about thirty-four years old, and though evidently something is wrong, no one would suspect it by her appearance or manner.

This case does not do me any credit as a diagnostician, but it does furnish food for thought. The woman is alive and seems now none the worse for her experience. Supposing that tubal pregnancy had been diagnosed in August, 1883, where would she be now? Certainly no better off than she is, and more probably in her grave.

And so I make an end of a story too long drawn out, with the hope that the defects of it in the telling, and the mistakes of it in the doing, may serve some one somewhere to do better than I have done. No one who has tried to do



well can look back on the work of years without intense regrets. That work must have been done poorly indeed that does not leave a man in the mental attitude of wishing he could go back again and do it all better; but, happily alike for the wise and for the foolish, there is no going back; only this, we can help somebody else to do it all better, and this is a higher joy than doing it ourselves.

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## HOMŒOPATHIC THERAPEUTICS APPLIED TO PELVIC INFLAMMATIONS.

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BY

E. M. HALE, M.D.,

CHICAGO.

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The members of the Missouri Homœopathic Society must not expect, in this brief paper, anything more than some thoughts on the above subjects, suggested to me by observations in practice, and a study of the recent researches in gynæcology.

The most important question which now concerns the practitioner of gynæcology is: Is there any such pathological entity as metritis, ovaritis, or salpingitis? Even if we admit the existence of inflammation in those tissues, can such an inflammation exist alone, without the previous or co-existing existence of a peritonitis? There are conditions, however, as when the mucous lining of the uterus or tubes is the seat of catarrhal or gonorrhœal inflammation, which may go on through their whole course, without any co-existent inflammation of any peritoneal tissue, provided the products of such inflammation do not gain access to the peritoneal cavity. But, by what I can learn from the writ-

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ings of the most eminent teachers of gynæcology, and investigators in the domain of pelvic and abdominal inflammations, there are very few instances where the parenchyma of the uterus or ovaries, or the muscular structures of the tubes, are the seat of true inflammation.

These observations are but a preamble to a question which has long been present in my mind, and which I am not able to solve to my satisfaction. It is this: Whence arise all the varied and almost innumerable symptoms which are found in our *Materia Medica*, and which are classed in the *schema* of our pathogenesis, as ovarian, uterine, vaginal, and so on? This is a graver question than may appear at first glance. Upon its solution depends much of our trust in the value of those drugs as curative agents, in diseases of the pelvic viscera. If we were called upon to classify drugs as to their affinity for the pelvic organs and tissues, we could only make three, namely, those which affect the muscular, serous, and mucous structures. But only a master in the art of interpreting symptoms will dare to make a classification which can be presented to the profession with any great claims to exactitude or trustworthiness. I have often attempted to make such a classification, but have never felt satisfied with my work, because there are some drugs which seem to affect all three tissues to a degree, and few which affect solely one tissue.

Were I to hazard a classification, I would place among the (1) *Muscular group*—Cimicifuga, caulophyllum, secale, ustilago, hydrastis, and perhaps pulsatilla, although this latter has a most special affinity for mucous surfaces. The others do not appear to cause mucous inflammations, or mucous discharges. One—hydrastis—appears to act only on the muscular coat of the blood-vessels. Sabina might be added to this group, also aletris and viburnum.

Now another question arises: Can we classify remedies which act upon the lumbar portion of the cord, and through

that medium upon the muscular structure of the pelvic viscera, as true muscular remedies?

Doubtless all these remedies do not act in that way, for we cannot imagine a drug acting on muscular fibre except through the motor or sensory nerves of those muscles. Now is it not a fact that really all the pains or painful sensations connected with the female generative organs are nervous or neuralgic? In this fact lies perhaps a solution of the question—Whence comes the pelvic pains found in the provings of all our drugs? Painful muscular contractions must have their origin in an abnormal state of the nerves which supply them. Sever those nerves at their origin, and no drug can reach the muscles to cause pain. The conclusion which I must arrive at is, that nearly all the subjective symptoms, caused by pain-causing drugs acting on the pelvic organs, are neurotic, and that they cannot remove, even when most carefully selected, only those conditions caused by the disordered nerves of those organs.

2. *Mucous Group*.—The drugs which appear to have an undoubted affinity for the mucous surface of the vagina, uterus, and tubes are pulsatilla, thuja, sabina, cubebs, copaiva, santalum, eucalyptus, sepia, and probably lilium. Sulphur and graphitis may have to be added to the list. It may be asked why I have not added a hundred or more drugs which are alleged to have caused blenorrhagic symptoms. I am sorry to reply that I feel obliged to doubt the genuineness of the provings of them. When you consider that hardly one prover in a hundred were at the time of proving perfectly healthy women, the source of my doubts will become apparent. The truth must be told, that not enough discrimination has been made by those who have proven, or recorded the provings by women. I am to blame as much as others. But it is a great responsibility for one to take, to reject symptoms made by provers, who believe they record genuine drug effects. The fault

lies in this—that in nearly all cases the provers were ignorant of the real cause of the symptoms. After taking a drug for a time, if a leucorrhœa appeared, or the menses showed some deviation from normal, they took it for granted that it was due to the pathogenetic action of the drug, when in fact the symptoms may have been due to many other causes and conditions to which the provers were subjected. For this reason, I, as well as all other compilers of provings, cannot separate the true drug symptoms from those not belonging to the drug. A symptom must be repeated many times, on many provers, before it can safely be set down as genuine. How many will survive this ordeal? The causes of discharges from the mucous surfaces of the generative organs are but two, namely, catarrhal and gonorrhœal. The first of these are generally amenable to internal treatment. The second being due to a specific germ, the gonococcus, are *not* influenced very much by internal medication. It is now an established fact that the manner in which copavia, cubebs, santalum, and thuja act is, that these drugs pass into the renal secretions, and then along the urinary tract, and kill the gonococci in their habitat. These drugs when administered to the female can only affect the urethra. Now urethral gonorrhœa is a very insignificant part of the disease in the female. It is in the fallopian tubes that they do the greatest damage, and there is where we cannot reach them by internal or topical medication. When their ravages extend only to the vagina and uterine mucous surfaces we are able, by certain agents fatal to the gonococci, to arrest their multiplication. We have been—before the investigations of Nœggerath and others—deceived into the belief that we had cured gonorrhœa in the female, when the external discharge had ceased. But we now know that this is no sign that the disease was arrested. No drug can produce a true gonorrhœa in either sex, consequently we have no specific for that disease. Many drugs can cause catarrhal

discharges from the uterus and vagina, and even the tubes. With these we may be able to cure such discharges.

3. *Peritoneal remedies*.—Have we any? If so they are few. If you will look in your works on homœopathic therapeutics and examine the drugs recommended for peritonitis, you will be astonished at their number. Yet out of the thirty or forty recommended, not five are really indicated according to the law of similars. In all the recorded cases of poisoning by the drugs in our *Materia Medica*, the only ones causing peritonitis are belladonna, mercurius cor., and turpentine. It is in vain that we look for real peritonitis symptoms in the proving of drugs, for no prover can carry his experiments far enough to cause even the initial stage of that condition. If you will consult the voluminous indications given by Lilienthal, you will see that all the symptoms, with the exception of those drugs I have named, are symptoms which are caused by intestinal neuralgia, or myalgic pains in the abdomen. Now while I admit that these remedies may be palliatives in a way, they are not really homœopathic or curative in peritonitis. The remedies upon which we most rely in the treatment of pelvic peritonitis are aconite, belladonna, bryonia, mercurius, veratrum viride, and colocynth. Now of these drugs only belladonna, mercurius, and possibly bryonia and colocynth, can cause peritonitis. We judge bryonia capable of this because it causes pleuritis and meningitis, and perhaps pericarditis. No post-mortem proof has been shown that it will do this, however. We judge from the symptoms, and we may deduce from analogy that it can cause peritonitis. As for colocynth we know well enough that it causes enteritis, and we know that this inflammation does often extend to the peritoneum.

Neither aconite or veratrum v. have been known to cause peritonitis. They are valuable only for the purpose of reducing the temperature and modifying the force of the heart's action. If homœopathic to fever they are secondarily so. Theoretically cantharis and sabina ought to be

homœopathic to peritoneal inflammation in the abdomen or pelvis. The homœopathic remedy for peritonitis must be a drug capable of causing primarily an acute inflammation of that tissue, with its consequent rapid accumulation of pus. I do not believe we have, now, such a remedy. I believe our treatment with aconite and belladonna, or veratrum viride, to be only preventive and palliative. When the inflammation has become established, and exudation or suppuration has set in, we have no drug which can resolve it, or cause its disappearance. The *knife* is here the sheet-anchor upon which we must rely. Laparotomy should be resorted to in all cases when pus has formed in any peritoneal cavity.

We should not wait for grave or dangerous symptoms, for then it is generally too late. I need not refer you to the success of the great abdominal surgeons of this decade. Their statistics are overwhelmingly in favor of early operations. Many of *our* school resort to full doses of opium, after the practice of Fordyce Barker and others, but that treatment is now abandoned by that school. Morphia hypodermically can safely be used, and should be resorted to for pain, when colocynth or dioscorea does not palliate. The plan of keeping the bowels open with saline laxatives is far preferable, in cases of septic peritonitis, than the constipation of opium. I have watched the results of their use in St. Luke's Hospital, Chicago, in peritonitis and in pelvic inflammations after operations, and I am satisfied that they are safe and useful. I prefer the Spanish "Rubinat-condal Water," to any of the laxative salts.

The continued use of poultices to the abdomen has seemed to me injudicious. If used at all I usually incorporate in them menthol and aconite, and enough mustard to redden the skin. In violent neuralgic-like pains phenacetine in 10 or 15-grain doses will often give prompt relief. Anti-pyrine should not be used.

## SURGICAL TREATMENT OF UTERINE DIS- PLACEMENTS.\*

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BY

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It is not by any means to be assumed, because the surgical treatment of uterine displacements is proposed, that all forms and degrees of malposition are to be thus treated. We shall all agree that a large proportion of these cases may be best treated and cured by general or constitutional treatment applied to the general debility, the nervous exhaustion, the pelvic congestion or engorgement, or other associated conditions upon which the uterine displacement may be dependent; by attention to the general physical development, the postures and exercises of the patient, to the relief of the pelvic organs from all superincumbent weight and pressure, and a judicious use of local applications, mechanical supports, and electricity.

But the fact still remains and will not be denied by any gynæcologist, and, I think, not by many physicians of any extended experience in this line of practice, that after all these means and measures have been faithfully and skillfully tried a considerable number of cases remain uncured and some not even relieved.

It is with this obstinate and troublesome remnant we have still to deal, and the question is: What shall we do for them?

I am well aware that some practicing the "mind cure," without giving it that name, advocate letting them entirely alone; diverting the minds of such patients from the cause of their sufferings, and endeavoring to convince them that they are really quite free from discomfort if they only think

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\* Read before the American Institute of Homœopathy, June, 1890.

so; while others assume that such patients should be content and satisfied to receive such partial and transient relief as can be found in continuous treatment, either general, local, or mechanical, and thus contribute indefinitely to the success (?)—no, the income of the attending physician; but this is begging the question. We have no right to be satisfied with anything which will not result in a cure of the difficulty, and anything which has in it the promise of such a result should command our attention and receive a faithful trial. In surgery we have such promise of cure for many of these otherwise incurable uterine displacements, and it is to the various methods and devices, their merits and limitations, your attention is invited and your experience and observations regarding them solicited.

We need not describe or even enumerate the various familiar operations upon the vaginal walls and perineum which have as their object the forming of a pillar, a pocket, or a ledge, upon which the displaced organ may rest, and I have little to say regarding them except to call attention to the weak point common to all of them and which causes them all to generally fail—or at best afford only temporary relief,—viz., the ignoring of the relation of the uterine axis to that of the vagina, or at least of the conditions upon which these depend.

It should be remembered that the natural position of the uterus is with its axis nearly at right angles with that of the vagina, and that while the firm yet elastic tissues of the intact vaginal wall furnish support to the cervix, the ligamentous attachments of the fundus to the brim of the pelvis are no less instrumental and no less important in maintaining the uterus in its normal position and relations, and that if these become so relaxed or extended from any cause that they fail to give due support to the fundus, retroversion or flexion may occur even though the inferior or vaginal support is unimpaired. It is generally recognized, I think, that prolapsus is secondary to backward displacement,—



*i.e.*, before the womb can descend much below its normal position, the fundus must be carried backward so that the axis of the womb will be nearly that of the vagina—hence, if the uterus is simply carried or pushed up, yet allowed to lie on the same plane with the vagina, as is the case with any of the vaginal operations, the weight of the organ itself, with that of superincumbent organs and external pressure, will be more than enough to force it like a wedge through any constriction made in the passage, whatever the device or the thoroughness of its application.

In attempting to improve upon abnormal conditions by surgical interference, we must endeavor to restore the normal or natural conditions, or devise something to correspond as nearly as possible to these, for we cannot expect to improve upon nature's perfect work. Therefore, in treating uterine displacements we must supply the superior support,—take in the slack in the guy-ropes, so to speak,—as well as restore the integrity of the inferior support or pelvic floor; neither of these can be properly ignored. Within the last ten years this natural requirement has received some, though not general, recognition, and various devices and methods of operating have been described and practiced, having as their object the maintaining of the fundus uteri in an anteverted or normal position, and with results far surpassing those previously attained. The special operation to be chosen must depend upon the conditions present in each case. For simple retroversion and for most cases of retroflexion, with or without dislocation of the appendages, and for all cases of prolapsus, when free from complications or adhesions, Alexander's operation for shortening the round ligaments is the one to be preferred above all others. It is simple; it is rational; it utilizes the natural supports without incurring any considerable risk or danger to the patient. It will be seen, however, that the class of cases to which this operation is applicable is very limited, as very few of the chronic, intractable displacements are free from

adhesions, or associated disease of the appendages; but I am convinced that its success is dependent upon these narrow limitations, and that the failures and disappointments charged against it have been due to its application outside its legitimate sphere, or in an unskillful manner. If the womb can be freely lifted into a normal position, the simple drawing of the round ligaments through the inguinal canals—which requires only a slight and superficial incision over the inguinal ring on either side—not only holds the uterus forward by these ligaments but gathers and gives tension to the broad ligaments as well, and if the uterus is normal in size and weight, very little strain is put upon these superior supports; if it be enlarged and heavy, a pessary or tampons must be made to aid in its support, and care taken in regard to posture and exercise until it becomes normal, when no artificial supports will be needed.

The exceptional cases of retroflexion in which this operation is not well indicated, are those in which the tissues are firm and elastic so that the flexion cannot be reduced and the uterine canal straightened except by a continued application of force to the fundus and cervix, and because with these conditions a constant and considerable tension and strain would be put upon the shortened ligaments, which might either detach them from their moorings, or so attenuate the ligaments themselves that no good result would be experienced. Some have made use of intrauterine stem pessaries to overcome the difficulty, but I prefer one of the other operations without the stem to Alexander's with it, because of the danger of inflammation and pain attending its use.

There are no other operations which seem to me worthy our present consideration, excepting those involving laparotomy: but I will merely mention three others which have been tried and described, viz: First, Suturing the denuded posterior surface of the cervix uteri to the posterior vaginal wall. Second, Stitching the anterior fornix of the vagina

to the anterior surface of the uterus with a view to drawing the latter forward upon the bladder. Third, Introducing a suture through the abdominal wall into the fundus of the uterus and out again; thus fixing the uterus to the abdominal wall without incision.

When disease of the appendages is associated with any form of displacement, laparotomy is indicated, and if it is found necessary or advisable to amputate one or both of these, then Tait's method of shortening the round ligaments, by including a loop of these in the ligature of the stump, is the best and simplest way of overcoming the displacement.

When removal of the appendages is not found necessary, or when, without disease of these, the breaking up of adhesions necessitates laparotomy, the uterus may be secured in an anteverted position by Wylie's method of taking a reef, or making a fold in each round ligament, securing it with one or more stitches, thus shortening the ligaments intra-peritoneally; or by Polk's method of uniting the two round ligaments in front of the uterus, thus drawing that organ forward and also making the broad ligaments more tense. It is also claimed that by this means the ovaries are lifted up out of the pelvis more than by any other method, and therefore making this operation preferable to others when prolapse of the ovaries is associated with the uterine displacement.

These are all simple, easy operations, involving very little risk to the patient beyond that of the abdominal incision unless complicated by extensive adhesions.

All in their different way serve to restore the natural support given by the ligamentous attachments of the fundus uteri to the brim of the pelvis, by taking up the slack—restoring the tonicity of these ligaments.

Any and all of these seem to me decidedly preferable to either of the operations for fixation of the uterus to the abdominal wall.

Either of these latter, whether the sutures and points of adhesion be at the cornua of the uterus, and on either side of the median incision, or at the top of the fundus, at a single point, is open to serious objections. First, fixation destroys that mobility which nature provides and demands, presents a dangerous complication in case of subsequent pregnancy, and creates a constant danger of intestinal trouble from hernia or volvulus, between the uterus and the abdominal wall. Second, as Dr. Emmett has very clearly pointed out, the distress caused by prolapsus is largely due to the traction, which when below a certain point destroys the tortuous course of the veins and results in engorgement; and the same traction with similar results attends the raising and fixation of the uterus above the normal position and for the same reason. Third, the danger of inflammation and suffering are greatly increased by introducing stitches into the fundus uteri and putting constant traction and tension upon the peritoneal attachments.

Because of these objections, although I have in two instances operated by this method with satisfactory results, I am strongly in favor of restoring the natural conditions by utilizing and repairing the natural supports, rather than creating strained and unnatural conditions by new artificial attachments.

To sum up in brief my observations and conclusions: In all cases of uterine displacement which cause any serious disturbance of health or any considerable discomfort and have proved intractable or incurable by ordinary means, surgical treatment should be applied.

Alexander's operation to simple uncomplication retroversions or prolapsus without adhesions, and to most cases of retroflexion.

Tait's operation to such as require the amputation of the uterine appendages.

Polk's or Wylie's operations for others which necessitate laparotomy either for breaking up adhesions, for accuracy

in diagnosis, or other valid reasons. Polk's preferably and especially if the ovaries are prolapsed and sensitive.

If we could feel that laparotomy involved no risk to the patient, there is no question but that the intra-peritoneal methods of shortening the round ligaments would render Alexander's operation obsolete, because they are more exact and sure in results, and decidedly easier to perform; but I do not feel that perfect security, so hesitate to open the peritoneum when the result can be attained otherwise, and equally satisfactory results have been attained by each of the different methods in my own experience.

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### CASES IN OBSTETRIC PRACTICE, WITH REMARKS ON THE RELATION OF HOMŒOPATHY TO OBSTETRICS.\*

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BY

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When asked to read a paper before this Society by our Secretary, the first subject which suggested itself to me was one which would treat on some branch of obstetrics.

When on searching through the "Annals of the British Homœopathic Society" I could find no paper that had any reference to this subject, I ventured to hope that from its novelty a paper on obstetrics might have an especial charm. But then, after further consideration, I found that such a subject, from its very nature depending only secondarily on medicines, would offer little opportunity for the consideration and discussion of homœopathic remedies, so I must ask your kind indulgence for what is to follow.

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\* Read before the British Homœopathic Society.

In the practice of obstetrics we must ever bear in mind we are dealing with a normal physiological process, and by assisting nature in her efforts, and the observance of scrupulous cleanliness, the great majority of cases do well.

On the other hand, the conditions under which we live—the effects of civilization—tend more and more to render these perfectly normal conditions exceptional.

It is no uncommon thing for the Hottentot mother, suddenly feeling the onset of labor, to retire into a corner of the hut, give birth to her child, and after a short time resume her usual occupations, much as if she had simply obeyed an ordinary call of nature. Such cases with us are rare, although not unknown.

I remember attending a primipara who gave birth to her child before my arrival, and on being questioned said she felt no special pain during parturition, and but for my injunctions to remain in bed would probably have been up and about as usual.

But the penalty of civilization is trouble during parturition, and diseased and ill-developed women have to suffer most.

The following cases, which have come under my notice, I trust will prove interesting and lead to a profitable discussion :

CASE I.—*Arm Presentation and Turning.* Mrs. B., the patient, it appears did not send for the nurse until the membranes had ruptured, and as soon as she arrived she observed the hand come down externally. This was about 6 P.M. I arrived about a quarter to eight, and immediately sent for a friend to give chloroform. By the time he arrived and I commenced to operate, the arm had been prolapsed fully two hours and a half.

I found the right hand projecting through the vulva; the dorsum of the hand was œdematous from pressure. By abdominal palpation I ascertained the head to be in the

right iliac fossa, and therefore it was an abdomino-anterior position.

The patient being under chloroform I passed my right hand, previously carefully carbolized and greased, into the vagina, and tried to push up the right shoulder. I did not succeed in this so I passed my right hand into the uterus to seize the right leg. At last I succeeded in getting my fingers into the popliteal space, and drawing down the right leg.

There were then presenting through the vulva the right leg and arm. I then passed my hand into the uterus again and tried to pull down the other leg, but did not succeed at first, the uterus being firmly contracted on the child and all the liquor amnii having drained away. I got the tip of my forefinger, however, into the child's anus, and hooking it round the ischial tuberosity managed to draw down the buttock. During these maneuvers I steadied the uterus from the outside, and tried to press up the head on the right side and the buttock down on the left.

In time I got hold of the left leg and drew it down. The rest of the delivery was readily accomplished. I prevented the arms from being extended and locking over the head by drawing them down. When the umbilicus was born the cord pulsated feebly, but when the child was born completely it would not breathe, and all efforts at artificial respiration and plunging the child into hot and cold water proved futile. Considering the time the arm had been prolapsed before I commenced the operation, viz., two and a half hours, and that all the liquor amnii had drained away, so that the uterus was tightly clasped round the child, I think the result could not have been expected to be otherwise.

Statistics show that one-half the children are lost and the mortality of the mothers is 1 in 9 in turning operations.

The rule for bringing down the leg opposite to the arm

presenting (namely, in this case the left leg) was quite impossible to carry out.

The mother made a good recovery.

CASE II.—*Shoulder Presentation and Turning.* I was called to this case in consultation by the doctor in attendance, who informed me that it was a transverse presentation, but he was sure the child was dead, so there was not any need to hurry.

On my arrival I found the head was in the left iliac fossa, and the left shoulder was presenting, it being an abdomino-anterior position; so I passed in my right hand, previously cleansed, disinfected and lubricated, but though I got hold of a foot could not bring it down.

I then prepared my left hand in a similar way, and passed it in and succeeded in bringing down the left foot. I soon after got hold of the right foot, and the delivery was easy till the head came, when the arms extended over the head and had to be drawn down separately. Then, after a good pain, the head was born with the cord round the neck, and the placenta followed at the same time. The child was dead, as had been foretold, and was a seven-months' foetus.

There was no post partum hæmorrhage, the uterus contracted firmly. The patient took the chloroform well and made an excellent recovery.

The interesting thing about this case was that although an abdomino-anterior position, the right hand, which in such cases is most easily passed along the child's abdomen, failed, and the left hand succeeded, showing that this rule is not always to be relied on.

In these two cases of transverse presentation could anything have been done by drugs? We read in the Pharmacodynamics that pulsatilla has the power in some cases to rectify mal-presentations, and Dr. Leadam even says it will sometimes restore a prolapsed cord.

If I get a case early enough before labor has set in, I



will certainly try it. I trust we shall hear the experience of members on this subject.

CASE III.—*Turning for Contracted Pelvis.* Mrs. C., who had previously given birth to several living children, although she had always had very bad times, sent for me. On May 3 labor had commenced at 10 A.M., and I found the os dilating and high up. I called the next morning and found the head had made no descent, but the os was dilated. The patient was very restless, so I resolved to apply the forceps under chloroform. I got a friend to give the chloroform, and, after emptying the bladder and rectum, I passed in the forceps. It was a high forceps case, the head being freely movable at the brim. I found no difficulty in applying the forceps, but the head refused to engage in the pelvic brim, although I tried steady and continuous traction repeatedly. It was evident the vertex would not enter the brim, so the forceps had to be abandoned. The pelvis, although contracted and small, was not notably deformed, and with the previous history of several living children born at term, I hoped to be able to deliver by turning. Version was performed without any difficulty, but at the same time the head was found to be large, in fact so large that it caused serious delay in its delivery and, as a result, the death of the child.

Here the cause of the dystocia was an unusually large, ossified head, occurring in a woman with a slightly contracted pelvis.

Unfortunately—or, as she would say, fortunately—this lady is not likely to have any more children; but should she again become pregnant I should induce labor at the eighth month, and deliver with forceps if there was any delay.

CASE IV.—*A Generally Contracted Pelvis.—Delivery by Craniotomy.* Mrs. W. did not send until the membranes had

ruptured, and on arriving the cord was prolapsed in the vagina. On vaginal examination the pelvis was found much contracted and the promontory of the sacrum easily felt. The two previous children she had given birth to were delivered by turning, and did not survive. I called in a friend in consultation, who carefully measured the pelvis, as follows: Between the ant. sup. iliac spines, 9 $\frac{1}{2}$  inches; between the crests, 10 $\frac{1}{2}$  inches; inclined conjugate, 3 $\frac{1}{2}$  inches; conjugata vera, 3 $\frac{1}{2}$  inches.

After this deliberate examination under chloroform, we decided that a living child could not pass through such a pelvis, so it was determined to perforate.

The presentation of the head was peculiar; both fontanelles could be felt on about the same level, and the posterior was just behind the symphysis pubis. The head was freely movable at the brim.

Having emptied the bladder and rectum, I warmed and lubricated the perforator, passing it up the vagina and through the os, protected by my forefinger. I felt the right parietal bone, and on this I steadied the point of the perforator, while I gave it a rotatory boring movement with the right hand. At first it slipped off the bone into a suture, but the next time I got a firm hold for the point in the bone. Then by steady pressure on the instrument I passed it through the bone up to the shoulders. I then pressed the handles, thereby opening the blades, and then gave them a quarter-turn and did the same in the reverse direction, so as to make a crucial incision. I then passed the instrument boldly into the cranium and freely stirred up the brain. This done I withdrew the perforator and passed through the same opening into the cranium the crochet, and by its means endeavored to rake out as much of the brain as possible.

Next I passed the cephalotribe in the same way as the forceps, having warmed and greased the blades. The blades passed very easily, but when I proceeded to screw up the

handles, they slipped the first time, so I withdrew both blades and re-introduced them. This time when I screwed up, the blades took a firm hold on the head, which when I had sufficiently compressed it, I proceeded to deliver by traction, using the cephalotribe in the same way as the forceps. Delivery was easily accomplished. The whole operation took I suppose from 20 to 30 minutes. The placenta came away quite easily a few minutes after. The uterus contracted firmly in spite of the chloroform, and there was no hæmorrhage. The patient made a tedious recovery.

As so often happens with our interesting cases, I have lost sight of this patient, but certainly this is just a case for the induction of premature labor in the event of her again becoming pregnant. Labor being induced at the seventh month a living child ought to be delivered by turning.

CASE V.—*Hydatid Degeneration of the Chorion.* For the notes of this case I have to trust to my memory, but the details are such that I shall not easily forget them. The patient, whom I saw with a friend, suspected nothing unusual to be the matter. She imagined herself to be in labor. The only unusual feature in her case was that for some weeks previously she had been losing quantities of blood. I confess the case was most perplexing. Vaginal examination showed the os to be soft and patulous, as at the beginning of labor, but no head or any other part could be felt presenting.

Within the os there seemed to be a soft mass resembling the placenta, and we concluded it was a case of placenta prævia. The uterus was enlarged to about the usual size at term. The chief feature in the case was the large amount of hæmorrhage, which was weakening and reducing the patient.

We decided to pass in a sponge tent, which was done, through a Fergusson's speculum, and left in the cervix, with

a view to checking the hæmorrhage, and at the same time to dilate it for subsequent operation.

We called later in the day, again passed the speculum, and decided to remove the tent. This was no sooner done, than a large gush of blood followed, with shreds of membrane. On examining these carefully we saw the characteristic cysts; and here let me say, in passing, that the cysts in the fresh state have only the very slightest resemblance to the blanched, ætiolated specimens we are accustomed to see in our museums. They were small, translucent little pellicles, about the size of peas, and containing a red, blood-stained fluid.

We now for the first time recognized the true nature of the case, and at once decided to empty the uterus as soon as possible as the only effectual means of stopping the hæmorrhage. This my friend did, passing in his right hand and with his fingers scraping out large quantities of the degenerated chorion.

The patient becoming very faint, I administered an enema of milk and brandy.

The hæmorrhage soon ceased after the uterus was emptied, and a full dose of *ergot* was administered.

The patient made a tedious recovery.

CASE VI.—*Vaginal Cystocele Complicating Labor.* Mrs. X. first sent for me one week before true labor pains commenced. When I saw her she had much bearing down, and a large tense tumor, about the size of the two fists, bulged out from the vulva, a truly formidable sight. I ascertained it to consist of the anterior wall of the vagina with the bladder. Behind this tumor, high up, the cervix could be felt, soft, but not dilated at all. I left her giving directions that she was not to strain or bear down, as she was not in labor.

A week later, I was again called to attend her, and, as before, the tense tumor came down. The os now was dilating, and true labor pains had set in. As soon as the head

entered the pelvis I managed to press up the tumor above it, and as the head descended it kept up the tumor, which gave no more trouble, and labor followed naturally.

This condition appeared but an exaggeration of the one so commonly met with where the anterior lip of the cervix gets carried down in front the head, and jammed between it and the pubic arch. When this is pushed up above the head, labor, which had previously been tedious, rapidly advances.

CASE VII.—*Placenta Prævia*. The patient, aged thirty-four, had given birth to three living children, and had had one miscarriage. The labor came on at six and a half months, and was accompanied with much hæmorrhage. The os was found dilating and the soft placenta could be felt within. The finger was passed in and swept round the lower part of the uterus, so as to detach the placenta. This was done, and then it appeared that the placenta was only partially over the os—a case of marginal attachment—for when this detachment was accomplished, the fœtal head could be felt on one side presenting. The membranes were then ruptured. The result of doing this was that the pains increased in force, and the os dilated more, and the head descended, very much checking the hæmorrhage. The child being premature, was now easily delivered, and the placenta came away afterward. The child was still-born.

The mother for some time after suffered from anæmia, and about a fortnight after was attacked with phlegmasia dolens, from which she made a tedious recovery.

And now, gentlemen, I come to the second part of my subject—What is the relation between homœopathy and obstetrics? What opportunities have we for the scientific study of drug action in the puerpéral state?

I think the answer must be that we have very few. We have only such opportunities as are met with in private practice, and these are necessarily very limited.

## DISCUSSION.

Dr. GOLDSBROUGH had attended upwards of 300 labor cases, and he considered that drugs were often of much service, especially in pregnancy. In the vomiting of the latter, ipec., kreasote, and apomorphia were of great value. In heartburn and other forms of dyspepsia, nux vom. was of service. During the fourth and fifth months a state of spinal irritation and nervous exhaustion was not infrequently met with, and here sepia or actea rac. act very satisfactorily. Collinsonia 1x was far preferable to aperients in the constipation of the latter months. During labor two medicines had served him well, viz: ignatia and pulsatilla, the former in exhausted states of the nervous system, and the latter in uterine inertia or fatigue. For this condition, where in former days it was customary to give a drachm of ergot, he now gave five drops of the mother tincture of pulsatilla. For after-pains he administered gelsem.  $\phi$ , two or three drops after each severe pain, and found it of much benefit. If this did not relieve, and the pains were referred mostly to the back and thighs, actea was given instead. In febrile conditions following labor, if originating in the uterus verat. v.  $\phi$  was the first medicine thought of; if in the mammæ, aconite or belladonna, or both. In inflammatory conditions, aconite, merc. cor., coloc., bry., or nux vom. (in a high dilution) were called for according to different indications. Injections of hot water with antiseptics were always of service. He believed the internal use of arsenic to be homœopathic to septic conditions.

Dr. NEATBY said calc. and silicea were of great value in preventing premature births. Arnica, secale, ignatia and gelsem. were very successful in relieving after-pains. In the vomiting of pregnancy he mentioned cocculus, in addition to those mentioned by Dr. Goldsbrough. Collinsonia had given him great satisfaction in relieving constipation. Puls. and op. had given him no results in promoting labor pains.

Dr. HUGHES said as it was possible for nature to rectify

a mal-presentation, so it was possible for us to assist nature by medicines. If the evidence was satisfactory, that was no reason to deny it. He confirmed Dr. Goldsbrough's remarks about the medicines he had mentioned. In delayed labor he never needed to give secale in material doses. One medicine that had not been mentioned in this connection was caulophyllum. This is called when the pains are irregular. Pulsatilla is best when the pains are weak from the first.

Dr. GALLEY BLACKLEY said he had found arnica given for a month or six weeks before labor of great advantage. Apomorphia in the vomiting of pregnancy had given good results. This bit of practice we owe to Dr. Dyce Brown, who was the first to apply it, Dr. Blackley himself having been the first prover of the drug. With regard to establishing a maternity department, he could not think that feasible with the present institution.

Dr. BLAKE said in China maternity was very fatal. It was not true that the women of uncivilized nations suffered less than those of civilized. The diminution of mortality was due largely to the spread of antiseptics. The substitution of vaseline for lard had done much good. Dr. Blake put on a binder before delivery, and tightened it after. He ordered a hot rectal douche immediately he entered the house. He advised obstetricians to use a warm antiseptic vaginal douche before labor in all cases by way of preventing ophthalmia in the child. He approved of fomenting the perineum before delivery. It not only tended to prevent laceration, but it also occupied the nurse. He had found homœopathy of enormous value in many of the side issues that crop up in every case. Tabacum relieved the vomiting of pregnancy, especially when associated with salivation. The heartburn of pregnancy was relieved by equal parts of carbo veg.  $\text{ix}$  and sodæ bicarb. crude; dose, one teaspoonful.

## HYSTERIA.

BY

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I have recently read Dr. Stella Hunt's paper on this subject in the October number of the *American Homœopathist*, and while expressing obligation for this compilation of the various and varying forms of this difficulty,—what is the remedy? And why does hysteria exist? And how is it developed? These are the questions; and they are left in the dark. No real light thrown upon the subject, only this, the writer has been careful to defend her sex, by showing that the male is also subject to that or similar forms of hysteria. But a disease equally shared does not help to solve the problem, if it were so; only tends to confirm what is here submitted. I do not say that I have solved the question, but I think my idea will help to point the way to a discovery.

My cases have all recovered under three of our remedies, gels., ignatia, and puls., and I include the hysteria globulus and clavicus, which borders close on to epilepsy. I will give three types in many cases, only describing one in each:

Mrs. I. L. When I first saw her, she had been in her family physician's (O. S.) hands some six months. I found her bandaged up legs and arms with red flannel, paralyzed, she said, and her doctor had told her. She was kept quiet by morphine. I told her there was no paralysis, and told her she could kick her foot out as I could, drawing my foot back to show by action. She instantly drew her legs up, and said, "Surely you would not kick me." "No; I told you that you could do that," and she did it. Her friends were surprised, thinking it was the medicine I had just given her, which was gels. id, a few drops in half a glass of water. She



got up and walked about ; then soon after she had stretching spells, in which she could pull her husband and me about, tear her hair, and smash things generally. Ignatia controlled these, and the tearful crying and loud screaming and vomiting were controlled by puls. But when these bad spells were on her, I would as soon as possible, by kind persuasion, get her on her side, when I would examine her per vaginam. In this and many other cases I found the womb swollen hard and prolapsed, the cervix tight closed and hot.

I invariably forced the womb back as far as I could reach, and in some cases placed a cotton wool supporter saturated with glycerine. This case underwent this treatment many times, and always with prompt relief, the intervals between the attacks growing longer, until they disappeared. Gels. was her principal medicine. This in the course a few minutes would cause the rigid os uteri to soften and relax, and when the cervical canal was open there was sure to be no more hysteria.

Mrs. Capt. S., another case. Tearful weeping or screaming or choking ; a great lump in her throat ; face very much flushed, neighbors very much alarmed, crowding the house. I at once placed her on her side and lifted the womb, which I found partly protruding, and hard and hot ; as I did so, she said "Oh!" and presently said, "I am better." I gave puls. and igna. in alternation, and went home. This was a midnight call. In the morning I found her cheerful, but very weak. I attended her for prolapsus, and I believe cured her, as in several years after I never heard of another attack.

Mrs. B. was one of the following kind : would froth at her mouth, bite her tongue, spit, swear, and tear any one she could get hold of, and then break out laughing, and so forth. This was another case of prolapsus, in which igna. was the principal remedy. By principal I mean the one the most used, or continued the longest. Treatment for pro-

lapsus of uterus cured all these cases ; and of a great many they are only samples.

In order to succeed you must have the confidence of your patients.

Then for the sleeplessness or insomnia, with spinal irritation, Gels. 3d was my constant remedy. Sometimes I gave it lower to promote a gentle perspiration, for in many hysterical patients there is a great dryness of the skin and a drying up of the salivary juices, or torpor of the salivary muscles. In those bordering on epilepsy the frothing is more from the stomach, as if there was a fermenting fluid working up ; for in such cases the tongue in many cases is large, red, and dry.

My reason for this treatment was because in a number of cases urine was passed while in the spasm. I was led to feel the parts, and found the womb pressed down, in some cases almost a complete prolapsed uterus ; and in these cases when it was restored the patient came out of the hysteric fit. This experience led me to seek for its confirmation or otherwise, and in every case of hysteria, where and when such examination could be made, my theory as to this being one of, if not the cause of this fearful complaint, was verified.

But then many hundreds of women suffer from all forms of prolapsus, and while all of them are more or less nervous yet this nervousness does not amount to hysteria.

I then began to watch the difference in cases of gynaecology that came to me, and I began to find that the nervousness was in degree according to the condition of the cervical canal. When it was open and there was a free drainage from within the uterus or a free ventilation, there was very little nervousness, though other symptoms of prolapsus were confirmed by touch and speculum. But when the cervical canal was closed or blocked up with mucus there was always great nervousness, sleeplessness, and bad dreams.

My idea is this, that in every hollow body there is a lining skin inside, filled with pores as the external skin, and that

through these pores there is a vapor escaping from the body, and that in order to be healthy every pore and hollow part of the body should and must have an escape-valve or vacuum, through or by which these emanations can get away. Now when the cervical canal is tight closed this vapor from the interior of the womb (and may be from the ovaries and tubes) cannot get away, and so is forced back upon the nerves or in some way becomes a nerve poison, producing these varying phases of nerve derangement, called for want of another or better name hysteria. I like the word *neurasthenia* better than that of hysteria.

The hysteric constitution may be a birth-mark, a transmitted mental matania; and this I believe to be always the case in men where it is a true hysteria.

I am so convinced of the reliability of the facts set forth, that I have planned a kind of uterine supporter with a means of holding open the cervical canal, thereby preventing conception in these cases, and the consequent hysteria and mania.

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## OVARIAN TUMOR—OPERATION—RECOVERY.\*

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BY

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PLYMOUTH, ENGLAND.

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Mrs. H., a woman of medium height and fair complexion, placed herself under my care as a dispensary patient in December last. Her age was then thirty-seven. She was married at nineteen, and had three children, the youngest being five years of age. She had never had any miscarriages. Menstruation had always been regular. Her mother died of some form of dropsy at fifty-two years of age. None of her relatives, so far as she knew, had suffered

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\* Also printed in the *Homoeopathic Medical Review*.

from tumors of any kind. She had never seemed herself since the birth of her youngest child five years ago. From that time up to the period when she came under my care she had observed a gradually increasing enlargement of the abdomen. The enlargement appeared at first to be more on the right side than on the left. Latterly she had suffered considerable pain in the right hypochondriac and right hypogastric regions. Walking provoked involuntary micturition. The appetite was impaired and the bowels costive.

On examination the whole abdomen was found to be distended by a collection of fluid. The quantity was estimated at from four to five gallons. Fluctuation could be transmitted in every direction. There was no enlargement of the superficial veins, the tumor projected in the middle line, and the left flank was resonant with the patient in the recumbent position. Apart from the abdominal symptoms, the patient had the appearance of being in good health. Pregnancy and ascites being excluded, the diagnosis of ovarian tumor was quite easy.

For a fortnight I gave her apis and merc. corr. for the relief of pressing symptoms, advising her at the same time to submit to an operation for the relief of her condition. After some consideration she gave her consent, and was admitted into the Devon and Cornwall Homœopathic Hospital in January. There she was placed on a liberal diet, including half a pint of ale or porter per diem. The bowels were regulated by an enema when necessary, and on the 24th at 9:30 in the morning the operation was commenced.

The patient was anæsthetized by my friend Mr. R. H. Geldard, L.D.S., the "A. C. E." mixture being employed for the purpose. I also have to acknowledge the valuable help rendered me by my friends Dr. Cash Reed and Dr. Alexander, without whose assistance I could not have undertaken the operation. An incision three inches long was made in the median line midway between the umbilicus

and the pubes. Pressure forceps were in readiness, but no superficial hæmorrhage required control. It is well to note here that the cumbersome and superstitious details of Listerian antisepsis had no place in this operation. Simplicity and cleanliness proved to be all-sufficient safeguards in the conduct of the case at every stage. The fluid was drawn off by a medium-sized syphon trocar and ultimately measured  $4\frac{1}{2}$  gallons, but it was not evacuated without much difficulty, as will now be shown. The cyst was strictly unilocular, and all went very smoothly till the tumor was about half empty, when the first and only real difficulty of the operation occurred. The cyst wall was firmly bound by adhesions to the adjacent viscera, which prevented its collapse. It became necessary to break down these adhesions, and in order to introduce the hand for this purpose the abdominal incision had to be extended an inch upward and the same space downward. On introducing the hand I found to my disappointment and consternation that the cyst wall was adherent at every point of its surface to the contiguous viscera; there was literally not one square inch of surface unattached. With great difficulty, and at the expenditure of much time, the cyst was at length stripped from its surroundings, but a piece of the omentum had to be cut off and left attached to the tumor, it being impossible to strip off such a delicate structure without laceration. For the same reason a piece of the cyst wall had to be left attached to the intestine. In each case hæmorrhage was prevented by the application of a silk ligature in the appropriate situation. The cyst was now thoroughly emptied, and drawn through the abdominal opening. The pedicle was firmly tied in two halves, by a double thickness of twisted silk, the empty cyst amputated and removed, and the first stage of the operation was complete.

There appeared to be very little hæmorrhage in the pelvic cavity, and none that required the application of a ligature. With a common Higginson's syringe, having its vaginal

pipe attached, the peritoneal cavity was now thoroughly irrigated. And here, I believe, the first and only error of judgment was made in the details of the operation, for instead of using plain warm water for the purpose, I unwisely employed a warm solution of corrosive sublimate. The solution was very weak; it could not have been stronger than 1 in 20,000; but I believe this was too strong considering the quantity of necessity employed and the possibility of absorption. After thoroughly cleansing the peritoneal cavity by the means described, the edges of the wound were brought together by three silver sutures, the surface dusted with iodoform, a thick layer of absorbent wool applied over the whole anterior surface of the abdomen, and a broad abdominal binder adjusted. The patient was placed in bed at 11 o'clock, the operation having lasted close upon an hour and a half.

The subsequent progress may be briefly summarized. For the first three days the patient was allowed nothing whatever in the shape of food or drink except ice. It is difficult to exaggerate the importance of this restriction. On the day following the operation she complained of nausea, a sense of bearing down in the pelvis, and she was jaundiced. The temperature, at first sub-normal, rose to 99° F. on the second evening. On the fourth day she was allowed milk, fruit, and beef-tea, and on the same day a pseudo-menstrual discharge appeared. By the end of the seventh day the wound had healed by first intention with the exception of a small opening at the upper angle. The sutures were removed on the fourteenth day, but meanwhile on the tenth day the temperature ran up to 100° F., and she complained of pain and tenderness in the abdomen. The pulse was 120, soft and full. Pelvic cellulitis had set in.

On examination of the abdomen a hard, non-fluctuating tumor was plainly perceived rising out of the pelvis. The swelling occupied mainly the left ovarian region, extending upwards as high as the umbilicus. This was an unwelcome

complication. While debating in my mind whether to evacuate the purulent formation through the vagina, the question solved itself by the abscess bursting into the rectum. A portion of the contents also found their way through the unclosed orifice at the upper angle of the abdominal wound. Through the latter opening a drainage-tube was inserted, while the tube itself and the surrounding cavity were kept clean and patent by syringing with warm boracic solution. The temperature ranged from 99° F. in the morning to 101° F. in the evening, with rigors and copious perspirations. On this indication I prescribed the following:

R̄ *Chin sulph.* 1x .....gr. 2, 3 h.  
 R̄ *Hepar sulph.* 3x.....gr. 3 nocte.

The course pursued by the abscess was most satisfactory. The purulent collection gradually emptied itself through the two channels, the temperature was controlled, and in the space of a fortnight nothing remained of the tumor except a little hardness at its original site. The patient had meanwhile been placed on a liberal diet, including half a pint of stout per diem, and the recumbent posture was rigidly enforced. Convalescence proceeded rapidly and without further interruption, and on the 10th of March she left the hospital cured.

The case appears to me to be interesting, and worthy of record for the following reasons:

1. It shows what an amount of rough handling the peritoneum will bear without peritonitis being set up.
2. It shows that a somewhat difficult and complicate case of ovariectomy can be safely and successfully accomplished without resorting to the complicated precautions of Listerian antiseptics.
3. It shows, lastly, that the resources of even a small homœopathic hospital are adequate to the performance of a comparatively formidable surgical operation.

## GERANIUM MACULATUM.

BY

PHILIP PORTER, M.D.,

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According to Dr. Shoemaker, *geranium maculatum* is one of the most valuable and yet the least known of American indigenous remedies. The portion of the plant used in medicine is the rhizome, or the root, stripped of its bark. The fluid extract is the most eligible and effective preparation, as it contains all the virtues of the plant.

There are few remedies which possess a wider range of usefulness than *geranium maculatum*, and which are so devoid of harmful properties. In all forms of hæmorrhage, whether internal or external, hæmoptysis can usually be promptly arrested by drachm doses of the fluid extract given hourly until the attack subsides. Relapses may be prevented by continuing the same dose at longer intervals for three or four days. Hæmatemesis may be effectually controlled in the same manner after the whole array of styp-tics have failed. In hæmorrhage from the kidneys and the intestinal canal better results can be obtained from the administration of smaller doses, twenty drops, four times daily, for an extended period. Epistaxis may be speedily checked by plugging the nostrils with cotton dipped in a solution composed of one part of the fluid extract of *geranium* and three parts of water, or by syringing the nasal passages with the same solution. Hæmorrhage resulting from the extraction of a tooth can invariably be promptly arrested by filling the socket with a piece of cotton saturated with the undiluted extract of *geranium maculatum*, and applying firm pressure for a few minutes. Menorrhagia can be most effectually abated by the internal administration of *geranium* combined with vaginal injections of the same remedy.



In severe cases it may be necessary to tampon the vagina with cotton soaked in a diluted solution of geranium or to inject the uterine canal with the same solution. This latter is the most effective method, but it must be resorted to with caution.

Cases of anæmia and chlorosis, in which the usual medicines have not been of any benefit, frequently improve at once upon drachm doses of geranium before meals. Amenorrhœa and other disorders of menstruation, dependent upon poverty of the blood, often disappear spontaneously during a course of geranium.

Diluted with water it forms an elegant and effective injection. It should not be used more than once every second or third day. Purulent cervicitis, fissures of the cervix, and catarrh of the body of the uterus and relaxation of the vaginal walls can be cured by the application of the fluid extract of geranium, either through the medium of an injection or by the ordinary cotton tampon and applicator.

The pain and irritation attendant upon fissure of the anus can be removed at once by touching the fissure with the undiluted extract, and a permanent cure effected by continuing the applications two or three times daily for a few days. Prolapsus ani will usually yield rapidly and not recur if the pure fluid extract be brushed daily over the protruding mucous membrane, and a 25 per cent. solution be injected into the rectum every second day. Ulceration of the rectum and anus may be rapidly arrested by the same means. The repeated application of the fluid extract will relieve the irritation and lessen the size of hæmorrhoidal tumors, and not unfrequently occasion them to shrivel up and disappear. The undiluted extract is without a superior in the treatment of fissured nipples. It relieves the pains at once, and forms a protective covering over the painful cracks, beneath which the healing process continues undisturbed. Unlike lead, the other commonly employed agents, it is harmless to the infant, and need not be washed off before nursing.

Sloughing and unhealthy sores rapidly assume a healthy appearance when continually bathed with geranium. Vaginal and intra-uterine injections are rarely necessary after delivery, but when the fetor of the lochia, or other symptoms demand their employment a decoction of geranium or 10 per cent. solution of the fluid extract will be as efficacious as solutions of carbolic acid or mercuric bichloride, and far more safe and agreeable to the patient.

Pruritus ani and vulvæ are due more frequently than is supposed to minute fissures of the skin of those regions, or to a relaxed and œdematous condition of the mucous membrane, and consequently can often be promptly removed by the application of a strong solution of geranium.

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## HYGIENE OF THE EYES OF CHILDREN.

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BY

H. H. CRIPPEN, M.D.,  
NEW YORK CITY.

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*(Continued from page 217, May, 1890.)*

HYGIENE OF VISION IN HYPERMETROPIA.—Hyperopia is the inverse of myopia; the parallel rays of light coming from infinity are, in the hypermetropic eye, brought to a focus behind the retina (Fig. 4). As in myopia, this displacement of the normal focus may be due to two causes: (a) An abnormal shortness of the antero-posterior axis of the eye by which the retina is placed in front of the focus of the dioptric apparatus. (b) A lack of curvature in the refractive media by which the focus is placed behind the retina. This last cause is extremely rare in children, as it mostly results from removal of the crystalline lens. We are therefore here only concerned with the first cause, the shortness of the antero-posterior axis. This is a congenital

condition, the result of a lack of development, and, as such, comes directly under our observance as a state in which timely efforts of prevention will serve as guard against the evils that can proceed from it.

With the focus for parallel rays *behind* the retina, it is easy to understand that in order to bring this focus forward *upon* the retina the hypermetrope must exercise an amount of accommodation that stands in proportion to the amount of far-sightedness, to the distance at which the focus is placed behind the eye when at rest. The hypermetropic eye then is seldom in a state of rest; the ciliary muscle always finds necessity for contraction during waking hours. But, besides this, the nearer objects are approached

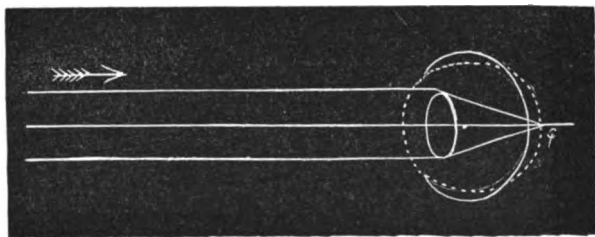


FIG. 4.—THE HYPERMETROPIC EYE. R. R. R., parallel rays of light are focused behind the retina.

to the eye the greater becomes the necessity for increase of accommodation, and work at a short distance in such children quickly becomes fatiguing; the ciliary muscle tires, just as any muscle would that is overstrained, vision becomes confused, the letters blur, and we are confronted by all the phenomena of *accommodative asthenopia*. These symptoms appear at a period which corresponds to the degree of hypertropia; the greater the degree, the earlier they appear. This asthenopia long continued may become an irritative condition, and among children it is very frequently the cause of blepharitis or conjunctivitis.

More than this, these efforts of accommodation provoke corresponding efforts of convergence. The greater the ac-

commodation the greater will be the amount of convergence, and thus the child is exposed to the danger of strabismus. Are not these serious conditions, that may arise from hypermetropia, sufficient to demand the necessary prevention means?

In order to avoid all these pathological states, that may affect children as a consequence of hypermetropia, it is necessary to have early recourse to convex glasses to assist the accommodation as much as possible in correcting the refractive condition (Fig. 5).

It is seldom necessary at first to correct the whole of the hypermetropia, because the child is accustomed to use the accommodation and involuntarily attempts to contract the

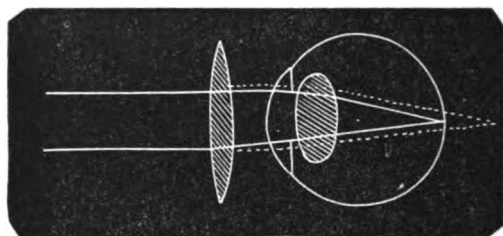


FIG. 5.—CORRECTION OF HYPERMETROPIA BY A CONVEX GLASS. V., convex glass.  
R., retina where corrected focus is found.

ciliary muscle, thus producing an excess of contraction and visual troubles. The convex glass ought to correct only the manifest portion of the hypermetropia and a small portion of the latent hypermetropia. Then, step by step, this last portion, that concealed by the contraction of the ciliary muscle, can be corrected until there is left little or no strain on the accommodation.

*Astigmatism.*—If different meridians of the cornea vary in their curvature it follows that their foci will differ. In the normal eye it is rare that the cornea has the same radius of curvature in every meridian, but this difference is so slight that it passes unperceived. But when the variation of the radius of curvature exceeds this small limit we have astigma-

tism. Thus, in Figure 6 we represent the meridian  $CD$  as having the normal curvature, parallel rays of light which pass through this meridian are brought to a focus at  $O$  on the retina  $EF$ . But the meridian  $AB$  has a longer radius of curvature, refracts rays of light less strongly, and hence has its focus at  $O'$ . Images seen by such an eye in the state of rest will be confused, and it is only by an exercise of the

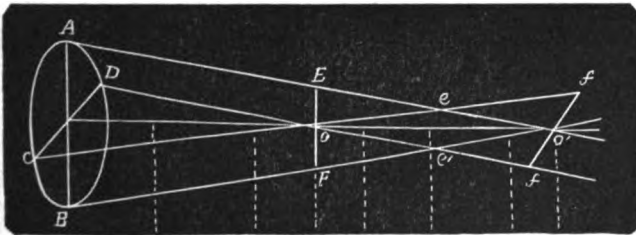


FIG. 6.—ASTIGMATISM.

accommodation, by changing the curvature of the crystalline lens, that any distinct image can be produced.

It is obvious that by varying the degrees of curvature in the diagram we can have several varieties of astigmatism. The diagram represents the eye as hypermetropic in one meridian and emmetropic in the other. It might also be myopic in one and emmetropic in the other; or hypermetropic in one and myopic in the other.

We need not continue further, the extra work imposed on the ciliary muscle will be well understood. The child affected by a stigmatism becomes the subject of asthenopia as soon as near work for the eyes becomes necessary, and the consequences of the irritable conditions to which such eyes are exposed in near vision can only be avoided by the proper cylindrical glass. With regard to the fitting of such glasses, the adjustment requires the consideration of so many ocular problems that a prescription for the relief of astigmatism is far removed from those not especially skilled in ophthalmology.

*(To be continued.)*

## ONANISM, A FREQUENT SEQUENCE OF GENITAL IRRITATION.

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BY

H. D. CHAMPLIN, A.B., M.D.  
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The average physician as a rule views with complacency and excessive satisfaction the great quantity of literature, good, bad, and indifferent, relative to gonorrhœa and other venereal diseases which the human genitalia are prone to encounter and become infected with, whilst the subject which heads my paper is dismissed in a perfunctory manner with a wave of the hand as disgusting and unfit for discussion; and yet like Banquo's ghost, "It will not down," but to the thoughtful and careful practitioner remains an incontrovertible fact; and I venture here to make the assertion that many children have been "doctored" for ailments foreign to their anatomy which were on careful investigation directly traceable to some form of genital irritation, easily remedied by such surgical treatment as the exigencies of the case demanded.

In the case of the human infant, personal hygiene of the genitals is a matter which seems to seldom enter the head of nurse or mother; the parts are packed in diapers so that urinary and fecal discharges continually bathe and moisten them, and more or less irritation set up. In these cases males are laboring under greater disadvantages physically than females. The girl's genitals are more prominent and their inflections within closer observation; the meatus urinarius is so close to the surface that the urine is ejected many times without contact with the adjacent integument.

In boys, the glans penis is covered by the prepuce and the meatus concealed, and many times some of the urine is

retained in contact with the mucous membrane of the glands and prepuce—undue excitement is set up, secretions, (smegma, etc.), increase and are pent up by adhesions, and irritation is not only kept up but intensified ; relief is sought by the boy through physical means—he rubs himself, but finds “tugging” at the prepuce is much more effectual ; continued pulling causes elongation ; the orifice contracts, at first spasmodically, later on organically, till in many cases the prepuce “balloons out” during micturition, and the excessive straining causes weakness of the abdominal walls—as a result, hernia.

This continued irritation of the genitals induces habits of manipulation (which too often, alas ! persist after the irritation ceases) and leads to the practice of onanism, which is kept up until after the age of puberty, thus causing a practice which at first was purely physical to become highly immoral and exceedingly disgusting.

Medical men know how much the mind and body, and especially before the spermatic glands have acquired their full power, are affected by sexual abuse or onanism.

In this class of cases as a rule parents will give much valuable information when we seek their aid in the matter and place it before them in the light of a “purely physical theory of manipulations” ; but under no circumstances suggest such a thing as Tommy or Jennie being “*moral lepers*,” and have them indignantly refute it and leave your office in high “dudgeon” to seek the advice of some other physician whose mental acumen enables him to arrive at the same point in a more devious but politic way.

The following out of many cases will perhaps serve to elucidate what I have tried to put forth in this short paper.

CASE I.—Male, age four years ; dark hair and eyes. Up to two years of age had been apparently well and hearty ; at that time commenced ailing and had run the “gamut of doctors” ; “he had been purged, puked, cod-liver oiled, and so on,” when he accidentally fell into my hands.

The child was weak, apathetic, could hardly drag one leg after the other, and was unable to stand any length of time, had been wetting the bed two or three times a night. On stripping him in my office I noticed his hand involuntarily sought his penis, and he commenced manipulating it. Examination revealed a long prepuce, contracted orifice, and an unusually excitable penis.

Circumcised him, and in one month he was a changed being; all manipulations ceased, and at this time, two years after, he is robust, fat, and pleasant to look upon.

CASE II.—Male, age six years; blond: blue eyes and light hair; has been in the hands of physicians, his mother says, "since he was three years old." His mother, "a sensible woman," informed me she had a night or two before noticed him (for the first time) manipulating his "organ." His expression was the most idiotic I have ever seen. Examination revealed a similar condition of things as Case I. Circumcision was performed, and his recovery rapid and progressive.

CASE III.—Girl, age four; Irish blonde; anæmic to an unusual degree, stupid, frequently makes crying. Leucorrhœa was profuse, and so offensive, child was repugnant to every one. On examination the parts presented a horrible appearance, raw and excoriated inside and outside of the labia and up on to the abdomen. The clitoris was as large as that of a full-grown woman, and *exquisitely sensitive*, so much so that when touched the child stiffened out and went through the motions of one who was enjoying the orgasm. Her mother was horrified at the state of affairs, but wished something done.

I made incisions each side of the clitoris and applied nitrate of silver (stick), and had the wounds irritated and kept sore for three weeks, then allowed to heal. Iodoform suppositories were used per vaginam and absolute cleanliness insisted upon.

She was under close surveillance for six weeks, night and



day. Improvement was constant from the first. Leucorrhœa ceased, parts healed up nicely as soon as the manipulation ceased, and clitoris had reduced in size one-third.

The girl is now hale and hearty.

I used no remedies in these cases, as there seemed no need of any. Moral suasion in one so young, also, it seems to me, has little if any effect.

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## ON PNEUMOTHORAX.

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BY

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The air contained in the pleura prevents the lung from expanding, therefore the respiratory murmur is either very feeble or is altogether absent, but auscultation of the posterior part of the lungs, where the lung is crowded up, reveals bronchial respiration. At the same time, the heart sounds are but feebly heard. It will be noted that while the affected side gives a tympanitic sound on percussion with little or no respiratory murmur, the healthy side gives a dull sound on percussion with an exaggerated respiratory murmur.

At times the vocal resonance has a distinct metallic echo, and when effusion has taken place, a splashing sound is heard when the patient is shaken gently. When the pneumothorax is encapsulated, no metallic sounds are heard; such cases are marked by a tympanitic percussion sound and absence of respiratory murmur.

An external examination of the cadaver shows that the affected side is still distended, and that, as in life, the intercostal spaces are still prominent. On opening the affected

side, the confined air rushes out with a hissing sound, though it is questionable if it is ever sufficiently strong, as some assert, to blow out a lighted candle. There is but little oxygen in the contained air, and its chief components are nitrogen and carbonic acid, together with an appreciable amount of sulphureted hydrogen. The amount of air varies very much, and Wintrich states that the more difficult it is for it to escape the greater will be its amount. The collapsed lung is crowded up against the posterior wall of the thoracic cavity; the diaphragm is displaced downwards, carrying with it the liver and spleen, and, as a rule, the heart is displaced laterally. A few rare cases of double pneumothorax have been noted; such a state would, of course, produce speedy death.

Pneumothorax coming on in the course of some far advanced pulmonary disease may be overlooked, especially if the symptoms are not well marked, but careful auscultations and percussion will soon clear up all doubt. Alarming dyspnœa coming on suddenly, with intense pain, followed by more or less collapse, and later by secondary pleurisy, point to pneumothorax and to that alone. Pneumothorax is further marked by enlargement of the chest and displacement of the heart, while the physical signs are a distinct metallic reverberation on auscultation, and tympanitic resonance on percussion with, but only occasionally, succussion sounds.

Of all the diseases of the lungs emphysema is most similar to pneumothorax. Both have an increased quantity of air shut up within the thorax, causing marked clearness on percussion; both have great and persistent dyspnœa; both are marked by feeble respiration; both have enlargement of the lungs with displacement of adjacent organs. But emphysema develops slowly; pneumothorax suddenly. Emphysema is generally bilateral; pneumothorax almost invariably unilateral. The intercostal spaces in emphysema are quite distinct, though more shallow than in health; in

pneumothorax they bulge out. Dyspnœa is present in both, but in emphysema it is more or less paroxysmal, while in pneumothorax it is continuous. Vocal fremitus is quite perceptible in emphysema; it is rarely present in pneumothorax. In both the percussion sound is tympanitic, but in pneumothorax there is, in addition, dullness at the lower part of the affected lung.

In large superficial vomicæ, as well as in pneumothorax, you hear amphoric respiration and metallic tinkling with an almost metallic ring to the percussion-sound, but the points of difference between these two morbid states are many and marked. Cavities are, as a rule, only found in the upper part of the lung; in pneumothorax the upper lobe is very rarely the seat of disease. The thoracic wall is depressed over a large superficial cavity; in pneumothorax dilatation is the invariable rule. In the case of large pulmonary cavities the heart is not displaced, but it is very often in pneumothorax. When a cavity exists râles are numerous and unmistakable, but in pneumothorax râles are few and faint. Lastly, when a cavity exists, the pitch of the percussion sound is altered by opening and closing the mouth, but this procedure has no effect on the percussion sound of pneumothorax.

Pneumothorax is less fatal in children than in adults, but still the prognosis is exceeding grave. This will readily be understood when we reflect that, in a majority of cases, the prognosis of phthisis is added to that of perforation of the pleura with its resulting pleurisy and suppression of the function of one-half of the apparatus of respiration. Still, though death is the usual result, pneumothorax is not inevitably fatal. Pneumothorax resulting from mechanical injury is the most favorable variety; and pneumothorax occurring in the course of pneumonia is more favorable than when it happens in the course of gangrene of the lungs. When a cure takes place, it is usually the result of the pleuritic effusion closing the perforation when the con-

tained air and fluid become absorbed or incapsulated, so that, as Gairdner points out, pleurisy is not to be regarded as a fatal complication but as a healing power. Dr. F. von Niemeyer's explanation of the mode of cure is somewhat different. He writes: "When recovery occurs, the pneumothorax first changes into a simple pyothorax, the liquid exudation accumulating in the chest, and so augmenting the pressure upon the air contained in the pleural sac that it is diffused among the adjacent vessels. Then, if circumstances favor, the effusion itself may be reabsorbed, and if meantime the orifice of the perforation be closed, the lung may expand again."

The general treatment of pneumothorax does not differ materially from that of advanced pleurisy. The strength should be sustained by food easy of digestion, and in certain cases nutritive enemata should be used regularly. Constipation is apt to harass the patient, and as all straining at stool must be avoided, it is well to empty the intestines by a daily enema of warm water and castile soap, especially if the constipation increases the dyspnœa.

I have seen great relief from warm poultices, frequently renewed, especially when the pleuritic pain is severe. Dr. Frederick T. Roberts has obtained great relief in some cases of pneumothorax by strapping the chest firmly; I have had no experience in this procedure.

Paracentesis thoracis has been highly recommended, but it must be distinctly borne in mind that in its very nature it is palliative, *not* curative. The pain of the operation is not great, neither is the risk, yet I would not perform it unless the dyspnœa was very urgent indeed, and under no circumstances would I perform it when pneumothorax occurs during advanced phthisis. Dr. Geo. B. Wood, indeed, says that "the operation is only warrantable when the accumulation of air is so great as to threaten speedy suffocation," and Copland believes that "recourse to this operation should not be delayed when pneumothorax has

occurred at any early period of phthisis, or when the patient is young, not greatly reduced, or whilst he has not advanced very nearly to a probable termination of a disease which would certainly end fatally, even if perforation of the pleura had not taken place. The operation itself consists in puncturing the thoracic wall through an intercostal space with the finest and sharpest of trocars, taking care to avoid wounding the diaphragm and the intercostal vessels. F. von Niemeyer points out that "the operation does not benefit the lung of the affected side, but rather the sound lung, where the mediastinum is displaced by pressure of the accumulated air and exudation, and hence encroaches upon the unperforated pleura."

As pneumothorax is always a secondary disease, the treatment must always be considered with reference to the primary disease. When the dyspnœa is very violent, arsenicum album will help in a vast majority of cases; it acts best in the triturations twelve to thirty. Should the pain be very severe, and especially if secondary pleurisy should develop itself with copious exudation, no remedy equals bryonia. A number of years ago, I sent to England for a supply of tincture of bryonia dioica—the black bryony—a common hedge plant in that country. I made a proving of it, and from that proving, supported by clinical experience, I am satisfied that in pleurisy and pneumothorax it is superior to our old friend bryonia alba. I use it in the 3d, 4th or 5th dilutions. Arnica, is of course, the remedy when the pneumothorax is the result of mechanical injuries.

#### APHORISMS.

1. Pneumothorax is rather an incident occurring in the course of certain pulmonary diseases than a distinct disease *per se*.
2. Pneumothorax is invariably a secondary affection, save when it is the result of a mechanical injury to the thoracic wall.

3. In children as in adults, pulmonary phthisis is the most common cause of pneumothorax.

4. The course of pneumothorax is always more rapid in children than in adults.

5. The affected side gives a tympanitic sound on percussion with little or no respiratory murmur; whilst the healthy side gives a dull sound on percussion with an exaggerated respiratory murmur.

6. Arsenicum album is the best remedy for the sudden and violent dyspnœa of pneumothorax, and bryonia alba, or preferably bryonia dioica, for the acute pains of secondary pleurisy.

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## LACERATION OF THE CERVIX UTERI.

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BY THE LATE

F. S. FULTON, M.D.

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*(Continued from page 240.)*

Of these different methods the preferable one is no doubt Emmet's, as we believe that in most cases this hypertrophy is more apparent than real.

The plan of trimming away the anterior lip, however, has been employed frequently at the Hahnemann Hospital with good results.

If there should have been any cysts left in the cervix at the time of operating, these should be trimmed away, as they will cause reflex disturbances and prevent satisfactory union.

If the laceration be stellate or bifid without to any great extent involving the outer cervical structures, nature will usually unite the parts, as they will be kept in apposition. If, however, the cleft involves to a greater extent the tissue of the cervix, and consequently does not heal, or if, from the profuse discharge, the woman is greatly weakened and

is not relieved by local treatment, an operation must be performed. It is not sufficient simply to denude and unite the vaginal surfaces leaving the canal as patulous as ever. No benefit will result from this, as the unhealthy secretion will continue to be poured out and, meeting the obstruction of the vaginal membrane, will dilate the canal still more and cause still greater reflex disturbances. In these cases, when the lacerations are close together and, as is usually the case, the tissue is greatly hypertrophied, a V-shaped piece, including the laceration and cicatricial tissue, can be removed. This can be done on both sides and the laceration then treated as a double laceration. If this is not practicable the cervix must be laid open by a free incision on either side, in the track of the old laceration. This incision must extend until the cervical canal is found to be of normal size. The point may not be gained until the internal os is reached. The diseased tissue, including the cystic mucous membrane, and the cicatricial tissue, must then be removed, the flaps brought together, and the incision treated as a double laceration. A less radical treatment will be of no benefit. The laceration in which the internal fibres of the cervix are badly rent must be treated in a similar manner, by freely laying open the cervix, removing the diseased tissue, reducing the canal to its normal size, and treating the whole as a double laceration.

Mrs. B—— presented herself at the Deaconess Institute for confinement. She was delivered of a dead child by the use of forceps, suffering a very severe laceration of the perineum, the rent extending through the anal sphincter, and also a peculiar laceration. Several months after delivery she was placed under my care for operative treatment. The cervix was enlarged, boggy, with erosions on the slightly everted lips. The cervical canal was plugged with characteristic thick pearl-like secretion. The lips were scarcely everted, but the canal was exceedingly enlarged and the uterus had not undergone proper involution. A

sound introduced in the canal showed that it was very greatly increased in size behind the thin stretch of mucous membrane, which covered the external portion and concealed the laceration. After the parts had been rendered healthy through the action of hot water douches and bell. tinct. internally, I operated. The cervix was first laid directly open down to the vaginal junction on both sides, disclosing a greatly enlarged canal covered with unhealthy mucous membrane studded with dark granulations. The canal of proper size was marked out by the knife and the diseased tissue cut away from both lips until it was all removed. A slight amount of mucous membrane was also removed from the lips in order to roll in their surfaces. The stitches were then inserted as usual, bent over toward the canal, and the patient put to bed. When the sutures were removed on the tenth day union was found perfect. A week later I operated upon the perineum with entire success. When the two operations of trachelorrhaphy and perinorrhaphy have to be performed upon the same patient, it is better to first perform the former, and the latter at a subsequent time. The reaction is better, the shock and pain much less. They can be done together, and I have performed both operations at once in several instances, but it greatly inconveniences the patient, and the result is not so satisfactory. If wire is used, which I think is preferable at all times, it is necessary to leave the sutures in the cervix too long before removal on account of the sensitiveness and weakness of the newly united perineum, which would only with danger of rupture and severe pain endure the stretching of the speculum necessary for the removal of the wire from the cervix. Everything is now ready for the sutures. The needles and material to be used have already been described. If whale tendon, catgut, or silk is used, they can be threaded directly into the needle and drawn through. If silver wire is used, for which I have a very great preference, the needle must be threaded with a



double thread of silk. The thread will need to be thirty inches long. It is doubled and the two ends drawn through the eye of the needle about three or four inches. Six or eight needles will need to be threaded in this manner. Some operators prefer to use but one needle and thread, adjusting the wire as they proceed. It makes but little difference which way is accepted. The former offers the advantage of being able to hold the cervical flaps more in apposition, thus favoring the insertion of the sutures and their more perfect coaptation. The needle is placed in the forceps at a convenient angle, and steadying the cervix by the counter-pressure hook or tenaculum the first suture is inserted at the outer angle of the laceration. The needle is entered about one-quarter of an inch from the denuded border and passes from the cervical mucus membrane downward to the bottom or angle of the denudation. Where the cervix is not greatly hypertrophied the needle can frequently be passed through both lips at once. It should emerge at a point opposite the entrance. The thread is then pulled through until the disconnected ends are free upon the further side of the cervix and the loop still on the other. These are drawn easily making a double thread on each side of about six inches, the needle removed, and the thread handed to an assistant who holds them against the corresponding buttock out of the way of the operator. Three or four such sutures are usually needed on each side. In the insertion of the sutures near the central portion of the cervix where it is thick and unyielding, it will be necessary usually to bring the needle out at bottom of the cleft and to reinsert it at the same point, carrying it from within outward though the second flap, as the cervix at this point is too thick and dense to allow of a needle penetrating both lips at once. As fast as the threads are adjusted as described they are handed to the assistant. The silver sutures are not introduced until all the silk threads are in position on both

sides. Great care must be taken to have the mucous strips designed for the lining of the new cervical canal in exact apposition. The wire is then taken, turned over at its end and hooked into the loop of the thread first introduced. The loop in the wire must be as small as possible to facilitate its being drawn through the tissue. It is best to squeeze it down to a point by use of the needle-holder or artery forceps before drawing it through. It is drawn through by a slight, quick movement from the wrist. It is then cut off, leaving about three inches on either side of the cervix. The ends are merely looped together and given to an assistant to hold. If twisted at this time it draws the flaps too tightly together and interferes with the drawing through of the remaining sutures. Each wire is introduced as above.

When all are in, those nearest the new cervical canal are drawn down, unlooped at their extremities, first straightened out, and then carefully drawn over the cervix and line of incision, and given a twist to hold them until they can be seized with the wire-twister. The edges must be seen to be well coapted, or else it must be done with tenacula. This shield or wire adjuster is then placed over the line of incision and around the wire which is twisted by the wire-twister until sufficient traction is exerted to hold the lips in good apposition.

*[(To be continued.)]*

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## ● EDITOR'S TABLE. ●

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—As a curiosity of diagnostication, the Chinese method of determining the state of the foetus is worthy of attention. "When the face of the mother is red and the tongue green, the foetus is dead. If the face is green and the tongue red, the infant is living but the mother will die. When the face and the tongue of the

mother are both green, the child and mother will both die at the same time." This is rather puzzling to obstetricians of the white race ; perhaps the chromatogenetic effect of pregnancy on the skin of the Chinese woman is different from that on her white sisters.

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—With the idea that menstruation is a manifestation of a general state, and that it is not a purely local phenomenon linked to the rupture of a Graafian follicle, S. Gikhareff has undertaken some observations on the blood-pressure of ten females before, during, and after the menstrual period. In conducting the experiments there was used a new instrument for measuring the blood-pressure, the sphygmomanomètre of Nasch, which gives results as exact as an aneroid barometer. It was found that the blood-pressure was perceptibly augmented some days before the menses, then lowered at the moment of their appearance. The author also adduces evidence from the oscillations of the muscular force of the pulse, of the temperature, of their radiation of heat, etc., that goes to confirm the cyclic theory of menstruation.

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—We venture to call the attention of the *Hahnemannian Monthly* to the fact that we possess a *sectarian* title, "*Homœopathic*," and that in crediting items taken from our pages, it is important, we think, to designate us by that title, "*HOMŒOPATHIC JOURNAL OF OBSTETRICS*," and thus avoid possible confusion with the obstetrical journal of the old school.

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—We have always had doubts on the medico-legal value of the so-called corpus luteum of pregnancy, and now comes Dr. Barton C. Hurst (*Med. News*), who states that he has seen two cases that might come under the heading of the "corpus luteum of pregnancy in non-pregnant women"; well-developed corpora lutea, exhibiting all the microscopic appearances of these bodies at the period of greatest development in a pregnant woman, and yet situated in ovaries taken from women beyond a doubt never pregnant.

—In the Dresden Clinic seven Porro's and twenty-eight Cæsarian sections were done during five years. All the mothers operated on by the Porro method were saved. Ten and seven-tenths per cent. were lost after Cæsarian section. It would be a mistake, however, to conclude that the Porro operation deserves the preference. The total result for the woman is much less favorable. Not only is the woman sterilized, but recovery is much more prolonged and hernias more frequent. On this subject Zweifel has said that amputation of the uterus is permissible only when it is unsafe to leave it. On this principle in the Dresden cases Porro's operation was performed in one case on account of a septic uterus, in another because general health forbade future pregnancies, in three cases for carcinoma, and in the remaining case because there was persistent relaxation of the uterus.

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—M. le Dr. Wacker has published in the *Therapeutic Gazette* a series of cases in which the salicylate of soda has been given to women, either for rheumatism or for metrorrhagias or dysmenorrhœa. He gave it to two pregnant females, one in her second month and one in the fourth month of gestation. A daily dose of 45 grains caused an abortion in both cases. In six parturient women the administration of the salicylate of soda caused in each a metrorrhagia and augmented the flow of the lochia; in one of these cases a fatal hæmorrhage followed the fifth day after accouchement. In five other cases the salicylate of soda, administered during or a little after the menstrual flow for the purpose of calming a dysmenorrhœa, produced a return of the menses without relieving the pain. Yet in nineteen out of thirty-three cases of dysmenorrhœa the author claims to have obtained favorable results by the use of this drug. Dr. Wacker has certainly pushed the use of the salicylate of soda to an unjustifiable extreme, and it is to be regretted that men who are so persevering in testing drugs do not accomplish more. If Dr. Wacker would turn his talents and opportunities to a more useful end by making a thorough proving of the salicylate of sodium on the healthy female organism, he would establish something besides an empirical result as regards therapeutics. As it is, the most that can be

drawn from his experiments is that this drug has apparently an abortive action, and that this depends upon the intense uterine congestion which it causes.

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—During the years 1866–1887, M. Bergh, of Copenhagen, has observed 877 cases of herpes of the vulva. In many cases the eruption appeared only before each menstrual period. The disease did not appear to depend upon any previous syphilitic lesion. In the majority of cases he considers that herpes of the vulva is a form of menstrual exanthemata probably dependent upon disturbances of innervation; the affection appears most often during the premenstrual period, and is manifested most frequently on the labia majora.

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—Generally the disturbances of pigmentation only show themselves, in the pregnant female, on the face in the form of chloasma and on the linea alba, which becomes brownish. But M. Tarnier has met with a case that departs from this rule. The woman arrived at the term of a normal pregnancy had on the chest, the thighs, and the abdomen, disseminated spots, from the size of a three-cent piece to that of a quarter of a dollar. These spots were brownish and the intermediate skin was paler than normal. This dyschromia would seem to be due to an unequal distribution of the normal pigment. The woman had an analogous eruption in a previous pregnancy, the spots beginning with the commencement of gestation and disappearing soon after accouchement.

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—Since there are many unsettled questions concerning oöphoritis K. Slaviansky's contribution to the normal and pathological anatomy of the Graafian follicle presents several items of interest (*Gazette de Gyn.*). He divides oöphoritis into parenchymatous, interstitial, and mixed. Parenchymatous oöphoritis is generally acute and terminates in regression of the follicles. Interstitial oöphoritis is either diffuse or localized in the perifollicular connective tissue. The first, the diffuse form, is, in general, of septic origin and can present several forms; serous, hæmorrhagic, suppurative, or necrotic. In the second form, circumscribed peri-

follicular oöphoritis, the inflammation is less intense, but terminates in the destruction of a number of follicles. This is the process described by German writers under the term "Kleincystische Degeneration." Here the Germans are quite in error, for, according to Slaviansky, this form of ovarian inflammation never has been seen to produce cystic degeneration. The follicles that are attacked degenerate, the perifollicular tissue thickens, becomes fibrous, and forms small bodies visible to the naked eye on the surface of the ovary. Inflammations of septic origin occasion a great development of the connective tissue, causing secondarily a cirrhosis of the ovary.

To the etiology of oöphoritis, the author adds rheumatism, the parotidites and some forms of sore throat. Tubercular oöphoritis is in general secondary. Among the symptoms, Slaviansky notes hyperæsthesia in the territory innervated by the genito-crural of diseased side. The ovary is especially sensitive to pressure in follicular oöphoritis; not sensitive in the cirrhotic ovary.

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—Formerly it has seemed a matter of chance whether a patient would or would not miscarry after an operation during pregnancy, but the number of cases which have been operated on without interfering with the course of pregnancy have now mounted up to such considerable figures that we can proceed to surgical measures, when indicated as a necessity, with great certainty of success. In this category of successful cases we may place the removal of a fibroid tumor from a pregnant uterus, which was performed at the Massachusetts Homœopathic Hospital by Dr. Horace Packard. Also five successful cases reported by Dr. A. W. M. Robson in *The British Medical Journal*. Of these five cases, one was a fibroid of the cervix uteri, removed in the seventh month of pregnancy; the second was a carcinoma of the breast, removed in the third month of pregnancy; the third was a multilocular cyst with extensive adhesions to the uterus, removed in the tenth week of pregnancy; the fourth was a case of strangulated hernia operated on in the third month of pregnancy; the last was an ovariectomy in the second month of pregnancy for acute symptoms caused by rotation of an ovarian tumor. All of these cases were delivered of healthy children at full term.

—Puerperal fever has been included in the Infectious Diseases (Notification) Act of Great Britain for 1889. By this law English physicians are required to report cases of puerperal fever in the same category as other infectious diseases. At first sight this seems like an imposition of extra and unnecessary work on the part of medical men, but a moment's thought will show that this act will have a great influence in lessening the number of those cases which are often spread by careless midwives.

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—At the Cincinnati Hospital the custom in the obstetrical wards is to give a vaginal douche of bichloride of mercury, 1-4000, at the commencement of labor, and one after the delivery of the placenta. Unless symptoms demand it this not repeated. It is customary to give a half-drachm of fluid extract of ergot after the delivery of the placenta.

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—A notable feature in the late gynæcological reports is the extraordinarily large number of cases of extra-uterine pregnancy which were reported as being saved by operation. The question naturally arises, first, whether they are genuine, or really cases of mistaken diagnosis, and second, granting that these cases are genuine, is not this accident becoming more common than formerly? Even after eliminating cases of extra-uterine pregnancy, reported cured by electrolysis, as possible mistakes in diagnosis there remain a greater proportion of these reports than has ever been noticed in obstetrical literature before. Improved methods and greater experience in diagnosis will account for a part of this increased proportion, growth of population will account for another small portion; but more than this, there is a strong opinion that the increased frequency of the accident can be fairly well explained by the greater number of women in all ranks of society in whom the mucous membrane of the fallopian tubes has been deprived of cilia by gonorrhœal or other inflammation.

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—Apropos of that controverted question, "Does the normal human ovary contain unstriated muscle fibre?" Mademoiselle

N. N. Ostrogradskaia (*Gazette de Gynécologie*) reports some observations. She has examined the ovaries of the new-born infant, of the adult female, and finally of a female at parturition (taken from a woman during Porro's operation). Muscular tissue was found in all these, and in an increasing proportion from infancy up to adult, and especially during pregnancy. It is probable, however, that these muscular fibres proceed from the ovarian ligament. Solid tumors of the ovary (containing muscular fibres) can, in the same sense, develop from the internal to the external border of the ovary.

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## • GOLDEN GRAINS. •

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—Prochownick substitutes the following diet in the place of induced abortion in cases of moderate pelvic contraction : "Breakfast, one small cup of coffee, 25 gm. of zwieback ; Dinner, meats, eggs, and fish, a small amount of green vegetables cooked with much fat, salad, cheese ; supper, the same, with 50 gm. of bread, and butter *ad libitum*. Water, soup, potatoes, pastry, sugar, or beer not allowed. As a beverage 300 to 400 c.c. of red or Moselle wine daily." In three cases of women with rachitic pelvic scoliosis, all of whom had borne children that could be delivered only after perforation and the use of the cranioclast, the use of this diet gave such happy results that their children were born at term and alive. They were all healthy and perfectly developed infants, but with scarcely any fat and less firmness of bone than normal.

—Dr. Amand Routh (*Transactions Obst. Soc. of London*) contributes three cases of urethral diverticula in women to the scanty literature on this subject. The *symptoms* are progressive discomfort and frequency of micturition, dyspareunia, and the formation of a swelling which appears at the vaginal orifice. Pressure on the swelling causes thin, offensive, irritating pus to pass into and out of the urethra. Cases are recorded showing that if these diverticula are left untreated, retrograde changes occur along the



urinary tract. The *physical* signs are unequivocal, differing on the one hand from dislocation of the urethra, and on the other from simple dilatation of the middle third of the inferior wall (urethrocele). The diverticulum is essentially a urinary pouch or cyst communicating with a urethra of normal calibre usually in its middle third, by an orifice relatively narrow. The *etiology* seems to be : 1. Closure of the ducts of pre-existing urethral glands, retention cysts resulting. Suppuration and ulceration into urethra by a small, often valvular hole follows, and the inflammation is kept up by urine trickling into the sac at each act of micturition. 2. Blood-cysts which have passed through similar changes. 3. The formation of pseudo-cysts by injury to the urethral floor during labor or instrumentation.

—Dr. M. Deis has collected a long series of cases of puerperal inflammation of the mammary glandular tissue, and embodied his researches in a thesis on puerperal mastitis. About 3.6 per cent. of lying-in women are attacked, the majority being primiparæ. In half of the cases the inflammation subsides without suppuration. Mastitis begins, as a rule, between the eighth and tenth day, and lasts from three to five days. The outer and externo-inferior lobes of the gland are the most frequently attacked. The temperature ranges from 100° to 104°, the maximum being usually attained on the first day of illness.

—French gynecologists are finding in the valerianate of quinine a new remedy for the treatment of uterine cough. This treatment, it is claimed, is solely effective in a purely reflex cough from uterine disturbances. In some cases where it has been successfully applied the cough was associated with vertigo and cephalalgia. Some authorities prescribe the valerianate of quinine in association with black coffee, thus :

Valerianate of quinine.....	19 grams
Infusion of black coffee.....	120 "
Simple syrup.....	40 "
One or two tablespoonfuls of this potion after meals.	

—Professor Poirier (*Le Progres Méd.*) presents in a series of articles the results of the injection and dissection of the lymphatics of the female genitalia in over 300 subjects. We are espec-

ially interested in these results with regard to the connection of the lymphatics with inflammations of the uterus and its appendages. We quote briefly the important facts: "My researches cause me to be of the opinion that in all uterine affections and their complications lymphangitis plays the fundamental part; if the inflammation be chronic, leading to induration of the cellular tissue (peri- or para-metritis); if more acute, giving rise to abscess, diffuse or collected, in the subperitoneal cellular tissue (peri-uterine abscess, phlegmon of broad ligament), or in the glands; or if caused by a very septic virus reaching the serous lymphatics by the path which I have pointed out (pelvic peritonitis)". As regards "phlegmon and abscess of the broad ligament" Poirier believes that the inflammatory process never begins in the center of that structure, but outside of it—*ergo*, in the pelvic glands along its outer border, and thence invading the cellular tissues of the ligaments. As to the pathogeny of suppurative salpingitis, the author comes forcibly to the support of the theory that the inflammation spreads by continuity along the mucous tract. Poirier holds, however, that in those cases of suppurating ovary following uterine mischief, and occurring without implication of the tubes, it is quite possible that the infection may have traveled along the lymphatic glands.

—Under M. Budin at the Maternité and Charité in Paris the following treatment for retention of the placenta after miscarriage is pursued: In simple cases, antiseptic vaginal injections, and the after-birth eliminates itself in general spontaneously. If there are grave complications: against hæmorrhage, the tampon is employed with all antiseptic precautions; against septicæmia, in the beginning, antiseptic vaginal injections are used every two hours, and even every hour; if the symptoms of infection are grave, intra-uterine injections are employed (corrosive sublimate 1-2000 or 3000, carbolic acid 3 per cent.).

—Loehlein (Transactions of the German Gynæcological Society, Heidelberg, Sept. 1889) has been able to follow the course of exfoliation of the mucosa during menstruation accurately and for a long time in twenty-five cases. The affection was observed six times in connection with puerperal or non-puerperal para, and peri-metritis,

four times in connection with abortion, two of them being after a badly attended, imperfect abortion, with protracted after-hæmorrhages. Four times (three of them in young girls) over-exertion and taking cold during menstruation, with suppression of the catamenia or their postponement after the action of various noxæ, was assigned as the point of origin, and once the influence of a damp dwelling, which had, besides, caused grave rheumatic disease in a young married woman. Twice the affection followed a recent endometritis; while chronic endometritis, both the glandular and the interstitial forms, was more frequently demonstrated during the curetting performed in the treatment of the disease. Of especial interest is the fact that among the relatively small number there were two couples of sisters, two unmarried women with neurasthenic taint, and two married sisters, one of whom had first observed the passage of membranes seven months after marriage; the other, sterile, though married seven years.

Of special importance, also, is the question as to the power of conception. Contrary to other authors, Loehlein observed pregnancy six times in his twenty-five cases. Of these six women, one had borne four children and aborted three times when the affection appeared, as it did, in connection with parametritis. After suffering for one year, she was curetted, when the membranes formed more rarely and were thinner. Conception followed. In four cases the affection existed three times before marriage. In two of these cases conception was preceded by curetting.

—In abdominal surgery, in ligating off pedicles and old, well-developed adhesions, and in securing the great arteries of the extremities, no material has yet been discovered which will take the place of silk, and none other should be used by the cautious surgeon, who always has a wholesome dread of secondary hæmorrhage.

—The indications for the employment of pessaries, and the methods of their application, have been summed up by Dr. Leake (*Revue Médico-Chirurgicale*) as follows:

1. There exists a great difference of opinion on the utility of pessaries, but the gynæcologist who has formed his opinions by long practice will never bow to the authority of those who reject

these appliances from want of proper understanding of the principles underlying their application.

2. The classic symptoms of pressure exercised by the uterus, such as the sensation of weight in the lower abdomen, pain in the sacral region, disturbances of the rectum and bladder, difficulty and pain in walking, dragging felt in the thighs and abdomen, etc., combined or not with uterine symptoms, are amenable to the proper application of a pessary. These symptoms should be regarded as an indication for the use of the instrument.

3. In all cases of anæmia, of neuroses, and of hysteria, a displacement of the pelvic organs may be at fault, and such causations should be sought for before proceeding to "guess work" treatment.

4. In the application of a pessary, attention must be given to the *natural mobility* of the uterus as well as to the normal position which it should occupy.

5. The Hodge pessary and its modifications are the most scientific and the most rational instruments that we possess. They should be used to the exclusion of all others.

6. Contrary to what is generally admitted, retroflexion can be remedied and the uterus maintained in its normal position by the traction lever pessary properly adjusted.

7. Pessaries should be placed and maintained while the woman is in Sims's position, for this is the most advantageous for the operation.

8. Pessaries, employed in the expectation that they would prove *curative* of displacements of the uterus, have not given satisfactory results, but by assigning them to their proper place, that of a *mechanical palliative* (the same as a splint to a broken limb), they will figure to advantage in future statistics.

—The usual anatomical statement that there are two broad ligaments instead of one has certain advantages in pathology which are sufficient to justify us in retaining it as a method of description. It is, however, not quite accurate, and occasionally it introduces a slight confusion. The real fact is that the two broad ligaments consist of but one fold of peritoneum, in which are invested the uterus and its appendages, together with certain survivals of foetal structure which happen to be symmetrical, or

nearly so. But the experience of disease often displays the fact that this fold is not truly separable into two parts, though the symmetry of its bilateral contents often leads us to forget or overlook the fact.

—The folds of the broad ligament have enclosed between them a number of blood-vessels and nerves. Any injury to or rupture of these vessels will cause an effusion of blood, and if the broad ligament be uninjured this effusion will be limited to its cavity, and be extra-peritoneal. If the broad ligament be injured, then the effusion may, and probably will, extend into the peritoneum and kill the patient. Some propose to term the former condition a “pelvic hæmatoma,” and the latter a “pelvic hæmatocele.” Like many other still more mistaken terms, “hæmatocele” has been sanctioned by long use, and new terms, unless giving a more clearly defined meaning or a better representation of pathological facts, are only provocative of confusion. The term “hæmatoma” answers to neither of these conditions and therefore is not acceptable. Broad ligament hæmatocele, according to Lawson Tait (*Edinburgh Medical Journal*), arises from three causes, and always by the same means. The direct agency is rupture of a blood-vessel, and that most always a vein. The first and probably the most common cause is the sudden arrest of menstruation by a chill, mental emotion, etc., by which an undue pressure is put upon the thin-walled veins contained between the folds of the broad ligament; following this a rupture takes place, and blood is poured forth into the cavity. Similarly, after operations, the blocking up of the blood-vessels by ligation of the broad ligament may produce an effusion of blood by the giving way of small capillary vessels.

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## ● GYNECIC ETCHINGS. ●

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—In the large majority of cases in which “birth palsies” are present there is a history of a difficult labor, or at any rate the infant was born “blue,” and there was more or less difficulty in bringing it round, the cyanosis remaining perhaps for some hours

after birth. The causes of asphyxia are of course various ; there can be little doubt, however, that there is an immediate connection between asphyxia and hæmorrhage from the pia mater, which damages the parietal regions of the brain, and gives rise to the well-known spastic paralysis (either paraplegic or hemiplegic) of infancy.

—During the dentition of infants do not forget that *Phytolacca symptoms* are : Crying, restless, and feverish, especially at night ; the teeth are a long time coming ; wants to bite something hard and feels relieved by it.—*Med. Era.*

—The acute arthrites observed among children are especially frequent during the first year of life ; they are ordinarily purulent. They often follow as a consequence of traumatism or of the exanthemata. Most often, however, these infantile arthrites are the result of an intracapsular lesion of an epiphysis. Their progress is rapid, they cause death in half the cases. More rarely they produce a more or less complete destruction of the articular extremities of the bones, luxations, pseudo-arthroses and shortening of the limb. Ordinarily these arthrites are seated in the hip, knee, or shoulder. The treatment consists in immediate incision, drainage, and antiseptic cleansing.—*Abeille Medicale.*

—Dr. Geo. M. Gould, in studies “on reflex ocular neuroses,” concludes that : (1) In headache *always* suspect eye-strain, and especially in women in the years between puberty and middle age. (2) In functional gastric derangements, not quickly to be explained otherwise, suspect eye-strain, and especially if headache co-exist. (3) In other functional derangements such as chorea, nervous heart, extreme irritability of temper, hysteria, etc., that do not yield to treatment, or that are not idiopathically or otherwise explainable, exhaust the possibility of a reflex neurosis from eye-strain or other peripheral irritation. (4) Have the refraction estimated, under a mydriatic, and the co-ordination of the external ocular muscles proved, by a scientific authority, *in the case of every child, before or by the age of puberty.*

—A cause of laryngismus, in very young children, is described by Dr. Goodhart as being found in the epiglottis ; for he states

that in one case of laryngeal spasm the epiglottis was excessively recurved in its vertical axis, as if it had been bent in half down the middle, and that thus the ary-epiglottic folds were brought almost into apposition, and a mere chink was left between them. It is said that more or less of this recurvation is a common thing in infancy and early childhood, and may explain some of the cases of laryngismus which would otherwise be swept into the net of convulsive laryngismus on account of the coexistence of a moderate rachitis. These symptoms gradually pass off with the development of the child and are little amenable to treatment. Another cause of laryngismus in very young children is given in the elongation of the uvula. One such case is noted by Dr. Alfred Mantle (*Brit. Med. Jour.*) in a child eight weeks old. We have also to record a case in a child of six months. In Dr. Mantle's case relief from the laryngismus was only obtained by excision of the uvula. In our own case the application of astringents to the soft palate and uvula was sufficient to stop the laryngeal spasm.

—The number of cases of genital hæmorrhages occurring among newly born infants, recorded lately, calls to mind the analogy that Camerer attempts to establish between genital hæmorrhage and melena neonatorum, basing this analogy upon the close identity of age at which these two affections most frequently occur. But genital hæmorrhage is confined to the female; melena occurs most frequently, but not exclusively, among males. Genital hæmorrhage usually begins on the fourth or fifth day, rarely impairs the health of the infant, and is unattended with fatal results; melena, on the contrary, usually begins during the first or second day, is very profuse, and is fatal in one-half of the cases. However, in those cases of melena in which no anatomical lesion can be discovered after death, save an intense hyperæmia of the intestinal mucous membrane, we grant that Camerer is justified in sustaining an analogy to genital hæmorrhage upon the basis of sameness of the pathological lesion, but taking the more usual and the graver forms of melena we fail to see the analogy. Melena may be the symptom of various anatomical processes which, from the subsequent history of cases of genital hæmor-

rhage, are presumably absent in this latter condition. Among these may be enumerated disturbances of the venous circulation, asphyctic conditions, pulmonary atelectasis, congenital diseases of the heart, enlargement of the liver and spleen, gastric and duodenal ulcer of intrauterine, embolic, or parasitic origin, fatty degeneration of the intestinal arteries, hæmophilia, and embolism of the umbilical vein. If the theory of delay in the establishment of the lesser circulation and respiration in the causation of melena could be demonstrated, the premature ligation of the funis would also acquire significance as a factor in the etiology of both these forms of hæmorrhage, and their analogy would be more probable. Embolism and blood stasis would be factors common to both. Nevertheless the infrequency of these affections, compared to the probable frequency of delayed lesser circulation and first respiration, constitutes an insurmountable barrier to the acceptance of the theory as a complete explanation of the causation. It may, however, offer an explanation for those cases of melena in which gastric or duodenal ulcers are present.

—Dr. Ballantyne (*British Med. Jour.* No. 1521) describes the clinical features of sclerema and œdema neonatorum. In both sclerema and œdema neonatorum the patients are weakly, often prematurely born, and in both diseases the body temperature rapidly falls below the normal. In sclerema the peculiar condition of the skin and subcutaneous tissues is found most markedly on the back, shoulders, and thighs, while in œdema the area of distribution corresponds with the lower part of the abdomen, the genital organs, and the back and legs. In sclerema the skin is firm and tense, cannot be raised in folds, and does not pit on pressure: in œdema, on the other hand, the skin is soft and boggy, can be pinched up between the fingers, and pits readily on pressure.

—Dohen (*Nouv. Arch. d'obst. et de gyn.* Nov. 1889), from a study of the mechanism of respiration in the new-born, at the clinic at Königsberg, reaches the following conclusions:

1. The respiration of the new-born is thoracic.
2. The elevation of the thorax begins at the summit and descends progressively.
3. The tidal air averages 35 c.c.m., and reaches a max-



imum of 120 c.c.m. 4. The exchange of air is feeble in the first days after birth ; at the end of first week it is a third larger than the first day. 5. Generally at the first inspiration the lungs are not filled with air, the alveoli unfolding only on the second day (a fact of medico-legal importance). 6. The respiratory curves of the new-born present no stationary points.

—Concerning œdema neonatorum Dumas (*Annales de Gyn.*) holds that it is a symptom of phlegmasia alba dolens developed within the first few days after birth. The pathological condition differs only in this, that in the infant thrombosis occurs more frequently than in the adult. The prognosis is graver in the new-born child than in the adult patient. For prophylaxis the author emphasizes the importance of fully establishing the respiration immediately after birth and of late ligation of the cord.

—There are a number of absurd statements made as to the capacity of an infant's stomach which have long passed current among the profession. At the end of the third month of life a child's stomach has a capacity of about five ounces, and at the end of the first year about ten ounces.

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#### BOOK REVIEWS.

A TEXT-BOOK ON DISEASES OF THE EYE. By HENRY D. NOYES, A.M., M.D. Royal octavo, 733 pages, richly illustrated with chromo-lithographic plates and 236 engravings. Price, bound in extra muslin, \$6 ; in sheep, \$7. New York : William Wood & Company.

The increasing demand for knowledge, on the part of the general practitioner, of the relations of the eye to the brain and nervous system, and, more especially, of the participation of the organ of vision in numerous general diseases, has created an enormous outgrowth of ophthalmological literature. Dr. Noyes presents us with the latest effort of this kind, a voluminous text-book for the use of the medical profession. But here is the great trouble, the work is too extensive to be much used by the general practitioner. This defect, however, the author remedies to a great extent, by supplying copious indices in which reference will be

found to passages where the connection of general diseases with ocular lesions is discussed. Particular attention is devoted to the relation of the eye to the nervous centers, and to the gynæcologist, who is constantly coming in contact with hysterical patients, these portions of the work will be valuable. With regard to hysterical amaurosis in particular, however, we confess that it is a great disappointment to find nothing on the subject except reports of clinical cases, and this after all that Charcot and others have written concerning it.

**ELECTRICITY IN THE DISEASES OF WOMEN.** By G. BETTON MASSEY, M.D. Second Edition. Enlarged and Revised. F. A. Davis, Publisher, Philadelphia, 1890.

That a work on electricity in diseases of women should arrive at a second edition is a strong commentary on the intense interest which Apostoli has awakened in this direction. Dr. Massey gives, besides Apostoli's method for the treatment of fibroids of the uterus, an efficient exposition of uses of the various kinds of currents in gynæcology. He has also included a number of original observations from his private practice that add much to the value of the book. The only criticism we have to make is that the author has not presented any decided conclusions upon the *contra-indications* for electricity in gynæcology.

**PRACTICAL ELECTRICITY IN MEDICINE AND SURGERY.** By G. A. LIEBIG, Jr., Ph.D., and G. H. ROHÉ, M.D. F. A. Davis, Publisher, Philadelphia, 1890.

This work, though much more pretentious than Massey's book, devotes very few pages to gynæcological subjects. Its chief interest lies in its exhaustive discussion of the modern theories of electricity as applied to general medicine and surgery, the first half of the work containing an exposition of the laws of electricity and descriptions of various electrical appliances, many of the latter, such as dynamos, microphones, Wheatstone's bridge, etc., never having been included before in medical text-books. In this way it will be found a very efficient adjunct to Massey's work, especially as the gynæcologist is so often called upon for practical knowledge concerning the working of electrical apparatus.

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## TEARS OF THE VAGINA DURING PARTURITION, AND THEIR IMMEDIATE REPAIR.\*

BY

W. E. GREEN, M.D.,  
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Lacerations of the female genital organs, incident to labor, have not received that careful attention at the hands of the profession that their importance demands. All the works on gynæcology treat of ruptures of the perineum, but only a few of the very latest contain well-written articles that include all the injuries that may happen to the pelvic floor.

When we consider the anatomical structure of the pelvic floor, and its physiological functions, we can readily understand that all injuries that impair the muscular structures are attended with prolapsus of the pelvic organs, and the evil consequences thereof. This subject has been one of consideration with me for the past ten years, and during that time it has been my invariable habit to make a careful

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\*Read before the Missouri Institute of Homœopathy.

inspection of the perineum and vagina after every case of labor that I have attended, and I believe that I have seen almost every form of rupture that could happen to the parturient canal; and the frequency of their occurrence, and the variety of their nature, has always been a matter of surprise to me. I have performed many operations for their repair, both primary and secondary.

The form of laceration that is most frequently met with is a division through the median line of the perineum. There are three varieties of this to be noted. The first includes only the integument, mucous membrane, and connective tissue, down to the muscular structure. Second, that which extends through the muscles of the anterior pelvic floor, varying in degree. Third, that which involves the sphincter ani muscle. A partial rupture only of the structures may be sustained,—viz., a subcutaneous separation of the muscles at their junction in the median line; a laceration of the mucous membrane, or of the integument alone, the other tissue remaining intact; extensive tears of the vaginal walls, that do or do not, involve the perineum, may take place; these vary in character, course, and extent.

The primary operation for the repair of these injuries is always to be preferred, for various and substantial reasons. It saves much acute suffering; in many instances, it averts septic infection; prevents the changes brought about by cicatrization and the evil consequences following the loss of functional power in the pelvic floor.

The principles that govern all surgical procedures obtain here,—viz., antiseptic cleanliness, clear-cut and evenness of surfaces, perfect coaptation of the wounded parts until union has taken place. Owing to the numbness produced by the pressure, it is often possible to operate without an anæsthetic.

To illustrate the subject, I cannot do better than to recite three cases that include most of the injuries, and embody the various operative methods used for their repair.

CASE I.—Mrs. B——, æt. thirty, primipara, was in labor six hours, head presenting L. O. A.; pains were weak and ineffectual. The short forceps were applied at the inferior strait, and the head delivered without great effort. Upon examination, I found the cutaneous surface of the perineum intact, but in passing my finger into the vagina I discovered a deep posterior laceration, extending from the muco-cutaneous junction almost up to the os, including the muscular structure of the perineum. This injury, if left to nature's efforts for repair, would have entirely destroyed the function of and the support given to the pelvic organs by the vagina and perineal body.

The patient was anæsthetized, placed upon the table in decubitus dorsalis, the thighs well flexed upon the abdomen and supported by two assistants; a sponge was introduced well up into the vagina, to stay the uterine flow, and a retractor introduced on either side to hold the labia well apart. Then with the scissors and forceps all ragged and uneven tissue was cut away, leaving regular and even surfaces to be coaptated; after thoroughly irrigating the parts the sutures were applied, beginning at the point near the os; medium sized catgut was used and the stitches were placed one-fourth of an inch apart, and were taken deep, so as to include all the torn structures. Intermediate sutures were applied wherever the parts were inclined to gape, so as to effectually prevent any leakage into the wound from the lochial flow. Nineteen stitches, in all, were taken. The patient was then put to bed and instructed to lie as quietly as possible, in the most comfortable position. When the discharges became offensive, daily injections of a carbolic acid and calendula lotion were ordered, care being taken that no injury was done by introducing the nozzle of the syringe. The recovery was prompt and satisfactory.

CASE II.—Mrs. P——, æt. twenty-four, delicate, frail woman, primipara. Vaginal outlet very small; vertex presentation, L. O. A. Patient very nervous and complain-

ing, progress of the labor very slow. Gave chloroform, applied short forceps at inferior strait, and delivered. Laceration of perineum extending down to the sphincter ani, including all the structures and reaching one and one-half inches up into the vagina. The same operative technique described in the previous operation was observed. After smoothing the surfaces with the scissors, three deep sutures were passed on the cutaneous surface, the same as in an ordinary secondary operation, but were not tied. Then, beginning at the highest point in the vagina, the mucous surfaces were brought accurately together with the requisite number of stitches; then the external ones were tightened and tied, which perfectly and successfully restored the parts.

CASE III.—Mrs. B——, æt. thirty-five, multipara. Had undergone previous operation for lacerated perineum; vagina and outlet small. Head presented, L. O. A.; expulsive effort strong; gave chloroform; delivery natural. Upon examination I found a laceration, beginning two inches up in the vagina, extending outward and downward into the anal orifice, including only the mucous membrane, skin, and connective tissue, leaving the muscular structure of the perineal body intact. Much trimming with the scissors was required to remove the ragged and uneven tissue, and put the surfaces in a condition suitable to insure the certainty of healing. Beginning at the vaginal end of the wound, it was closed throughout by twenty-four successive stitches, taken so as to insure perfect coaptation; the last one was placed within the anal verge. No deep sutures were required, as none of the muscular structures were involved. The patient had a perfect recovery and suffered but little from pain or inconvenience.

I have never performed a primary operation for a laceration that included the sphincter ani muscle, as I have not met with that accident in my own practice. I have done the secondary operation with perfect results, and would



adopt the following method in a recent case. After trimming away all the ragged tissue, the torn surfaces of the bowel should be brought together with medium-sized cat-gut sutures tied within the gut. The divided ends of the sphincter muscle should next be secured and the ligatures cut short; then in the same manner, building up the perineal body, burying the sutures as the process goes on, finally uniting the skin and mucous membrane with superficial stitches.

To insure success in any of these primary operations, it is imperative that the vaginal side of the wound, the tear in the mucous membrane, should be accurately closed to prevent infiltration of the vaginal discharge and consequent septic infection. When carefully and properly performed these operations always give favorable results; therefore, every rent, if only of slight significance, should be repaired.

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## A PLEA FOR EARLY OPERATION IN UTERINE CANCER.

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BY

JOHN W. STREETER, M.D.,  
CHICAGO, ILL.

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Of all cases of malignant disease of the womb, more than ninety-five per cent. commence in the cervix. In two varieties (cancroid ulcer and cauliflower growth) the tendency is to remain limited to the cervix and surrounding tissues for a considerable time, the natural growth of these varieties being by means of infiltration in continuity of tissue; while the *third* variety is local in the cervix an indefinite and comparatively short time, its methods of growth being both by continuity of tissue and by migration of its cells.

We believe that in all varieties of cancer and in all cases, the affection is *local at first*. We believe that there is no general infection, no cachexia, no dyscrasia, and no constitutional taint until time enough has elapsed to contaminate the system from the local disease.

The channels of contamination are numerous, the disease is aggressive, and it is but a short time usually before constitutional symptoms appear. The migration of cancer cells, through lymph spaces and canals, into the blood is a well-established fact. It is also true that wherever one of these cells finds lodgment, there it builds its nest, finding in the connective tissue of the part congenial soil in which to grow and multiply. This is one means of systemic contamination. Another is found in the production of septic fluids by the breaking down of tissues which are the seat of cancerous infiltrations; a general sepsis is established by the absorption of these fluids. Add to these the shock of persistent pain, the anæmia caused by hæmorrhage, anorexia, and imperfect digestion, and the mental depression which is common in this fearful disease, and we cannot wonder that the face soon gives evidence of the deadly attack which is being made upon the organism.

As a result of some perversion in the blood or nerve supply of a part we find a low grade of cells developed in that part. Instead of well-formed and healthy epithelial cells we find imperfect, atypical ones, which have a wonderful power of proliferation. They divide and multiply until they have crowded out all healthy tissue cells.

A crowding together of atypical epithelial cells in irregular alveolar spaces in the connective tissue of a part *is cancer*. It is growth without rule or law, and is, of necessity, imperfect in bulk and in cell. This imperfection is the head and point of its malignancy,—a low form of life developing rapidly, dying rapidly in strict accord with a general law of nature.

Believing as I do that all cancers are originally local, and

that in their early life they can be successfully treated as such, I make this plea for early diagnosis and early surgical interference. I do not wish to depreciate constitutional treatment but to supplement it by removing the source of infection; as I would remove a decaying fragment of placenta, while I gave arsenicum for the sepsis it has caused.

Early diagnosis is of the utmost importance, for it is only the early operation which gives future immunity. If we wait for the classical symptoms—pain, hæmorrhage, and offensive discharge—we have waited until our patient is practically beyond help. Pain does not come until the disease has extended beyond the limits of the cervix; hæmorrhage arises from the corroded wall of some vessel, and offensive discharge from the disintegration of tissue. It does not require a surgeon to make the diagnosis when these symptoms are present, but it would require more than surgical or medical skill to glean favorable results from such doubtful fields.

There are no symptoms, objective or subjective, which are pathognomonic of early uterine cancer. The microscope is the most reliable test, and it should be resorted to in all doubtful cases. Expert touch is second only to the microscope; there is conviction which amounts almost to certainty in the tip of the educated finger; but this is only acquired by wide experience. I believe it is a good rule, in doubtful cases, to give the patient the benefit of the doubt by removing the offending cervix. A woman may get along very comfortably without a cervix uteri, but she is not likely to live two years with carcinoma uteri. Early diagnosis, prompt surgical work, and well-advised constitutional treatment will accomplish wonders in this terribly fatal disease.

There are three methods of surgical interference which are variously applicable to different stages of uterine can-

cer,—viz., high amputation, hysterectomy and, curettment, with sloughing by the zinc chloride.

High amputation of the cervix is correct when we are reasonably certain that cancerous infiltration does not reach as high as the os internum. To be reasonably certain of this we must find healthy, supple tissue extending entirely around the intra-vaginal cervix. If the whole of one (or both) lips is implicated we are forced to the conclusion that the disease has extended to or through the os internum, and that this operation will not be sufficient. There are many ways of doing high amputation. I will call attention to two methods, which are simple and effectual.

First, amputation by means of the galvano-cautery, as practiced extensively by Byrne of Brooklyn. The wire should be carried a little above the vaginal insertion and evenly applied while cold. The cervix is to be firmly grasped by a strong vulsellum, and gentle traction made. When the current is turned on, this traction is to continue, that the wire as it burns its way may cut higher and higher upon the cervix. The result is a convex amputated part and a concave uterine stump. A probe electrode should now be passed well through the os internum to make moderate destruction of tissue there. This method has given excellent results, and it has the advantage of being nearly bloodless. The eschar falls off in a few days and the wound heals kindly and rapidly.

The other method is by knife and scissors. A No. 9 Pratt's sound, with a canvas cover on its handle, is passed into the organ, each lip is transfixed with a strong thread, and each thread is made fast to the canvas cover. This gives the operator perfect control of the organ, and the sound is the director upon which to cut. An incision through the mucous membrane is carried entirely around the cervix. A small strong forceps should be now applied to the connective tissue on either side of the cervix to control the circular branch of the uterine artery. With sharp-pointed

scissors, slightly curved on the flat, one may now gradually make way toward the sound from all sides evenly, and with a progressively upward tendency. The result, as in the former operation, is a cup and saucer amputation. It is usually wise to leave the hemostatic forceps in place for twenty-four hours. If the case is correctly diagnosticated, either of these operations should eradicate the disease. But if the cancer cells have penetrated as high as the os internum, more radical measures must be employed. Thanks to recent improvements in the technique of vaginal hysterectomy, it is now possible to practice radical methods with reasonable prospects of success. Vaginal hysterectomy with forcipressure to control hæmorrhage is as safe as laparotomy done under the most favorable conditions, i.e. the mortality should not exceed five to eight per cent. This operation should be resorted to in all cases in which the disease has extended to the body of the womb as well as in those (few in number) in which the affection is originally a *corpus carcinoma*.

In selecting cases for this operation we must be reasonably certain that infiltration has not extended beyond the body. If there is fixation of the uterus, if the retro-peritoneal glands are enlarged, or if there are other reasons for believing that the disease has extended beyond the limit named, we are warranted in putting the woman to the peril of the operation: We should never resort to hysterectomy simply to alleviate symptoms,—a reasonable prospect of *cure* is the only warrant.

*Palliative treatment* can be as effectually accomplished by easier and safer methods. Well-selected cases should be *cured* by hysterectomy.

It is not necessary for me to describe this operation, which has been so much talked about and so much improved during the past three years. I will simply call attention to two slight modifications in the technique, which I have found useful. The first is the use of the blunt hook

in drawing down the upper border of the broad ligament, that it may be more easily and surely grasped by the long forcep. The other is a modification of the Byford broad-ligament forcep. I have increased the length of blade and made it unlock and lock at quite an acute angle. This facilitates the introduction and the removal of the blades in some cases. I would suggest that all forceps used for hæmostatic purposes should be sufficiently strong to *crush* the tissue grasped, and that they be removed within twenty-four hours. This will prevent in some degree the extensive sloughing which is sure to follow when they are left two or three times as long. In my second case, in which the forceps were left in place for sixty hours, the slough extended so as to corrode the right ureter, and on the eighth day I found that I had a uretro-vaginal fistula, which was only cured by some very careful plastic work. The lesson taught by this accident was to remove the forceps as early as it may be safely done, and in this way prevent extension of the slough beyond the grasp of the instrument. We are warranted in expecting excellent results from this operation in well-selected cases. Its sphere of usefulness is wider than that of the high amputation, but it is still limited by the narrow bounds of the peritoneal covering of the uterus.

In another group of cases (and I fear it is the largest one), the disease has extended beyond the reach of surgical skill before help is sought. This group may, in a general way, be said to include all cases in which the classical symptoms of pain, hæmorrhage, and offensive discharge are present in a marked degree. Easy of diagnosis, hopeless in treatment; all that is left for us to do is to mitigate suffering, and make the short span of remaining life as comfortable as we can. Surgery can do no radical work here, but it can alleviate the pain, check the hæmorrhage, and prevent the offensive discharges, and by these results make life tolerable. This is best done by the thorough use of the curette and the zinc

chloride packing, after the plan first suggested by Sims and perfected by Van der Worker. The curette is first used until all friable tissue has been removed from cervix and body. The excavation thus made is to be carefully packed with small pledgets of cotton, squeezed rather dry from a saturated solution of zinc chloride. Great care must be used in protecting parts which are not to be sloughed. A plug of cotton soaked in a strong solution of bicarbonate of soda is now applied to the cervix, and the whole vagina packed with dry cotton. About the ninth day the whole mass will become loose and can be removed. With, or following, the plug will come a thick slough of uterine tissue, which has the general outline of the cavity you have made. The excavation is now in a state of healthy granulation and will heal quickly. The organ is sometimes so reduced in size that two months after the operation it may be no easy matter to find it, and you will discover that you have virtually done an extra-peritoneal hysterectomy. In other cases the operation will have to be repeated, but you may be certain that your work will have the effect of making your patient more comfortable, and that she will not die with the symptoms of uterine cancer.

This urgent entreaty for early surgical interference does not contemplate the loss of any tissue which could be saved by the most conservative treatment, for all tissue which is invaded by cancer cells must die and be cast off. Neither should these methods come under the condemnation of those who believe that the knife is a positive and direct irritant to cancerous growths, for our aim is to avoid the disease and make a clean wound in healthy tissue, which will heal as kindly as any other wound.

After twenty years of serious study and wide clinical experience in this branch of surgery, I am willing to venture my reputation on the statement that the early life of uterine carcinoma is *entirely local*, and that it can be eradicated by local methods.

## A REPORT OF EIGHT CONSECUTIVE VAGINAL HYSTERECTOMIES FOR CANCER.\*

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BY

J. M. LEE, M.D.,  
ROCHESTER, N. Y.

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CASE I.—Mrs. Y—— of Rochester, aged thirty-nine years, was married when twenty, and is the mother of seven children. Her menses appeared at fourteen, and remained normal until February, 1889, when she had a severe uterine hæmorrhage. The flow did not fully subside, and at the next month the hæmorrhage reappeared and was more copious.

She came under my care, and a large amount of diseased tissue of the cervix and body of the uterus was removed with Sims's sharp curette. Her pain subsided and she rapidly gained flesh and strength. July 1, she again had an alarming hæmorrhage.

As soon as she had sufficiently recovered she entered the Rochester City Hospital, and on July 9, kolpo-hysterectomy was performed, after the method of Greig Smith of London, England. The uterus was easily removed, but one of the Smith broad ligament clamps slipped, and it was a difficult task to secure the many bleeding points through the depth of the vagina. On section, the greater portion of the uterus was found to be infiltrated with cancer. The patient had very little shock; the highest temperature was  $101\ 2.5^{\circ}$ , and there were no alarming symptoms during her entire recovery. The twenty-first day after the operation I gave her permission to call a carriage and go home, but she informed the nurse that I knew she was not able to hire a carriage, and, much to my surprise, walked home. However, this

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\* Read before the American Institute of Homœopathy.



did her no harm, as she immediately assumed charge of her household duties. It is now nearly a year after the operation, and she is caring for a family of seven.

CASE II.—Mrs. W——, a widow, fifty-six years of age, the mother of two children, presented herself for examination February 28, 1889. She was sent to me by Dr. McPherson of Palmyra. She appeared to be a healthy woman, and would have passed for such, but for an insignificant backache and a watery vaginal discharge, which had scarcely attracted her attention. Nothing could be seen but a small point of granular tissue in the cervical canal. The following day the uterus was dilated and a considerable quantity of broken-down tissue removed. The growth involved the entire organ to such an extent that it was impossible to remove it with the curette. The microscopic examination showed the disease was mixed celled sarcoma.

Two weeks later the patient entered the Rochester City Hospital and kolpo-hysterectomy was performed. The texture of the uterus was so weakened by the disease that it would not bear the necessary traction without tearing. This, together with the slipping of one of the clamps, complicated the operation considerably, still it was completed within forty-five minutes.

She recovered promptly and left the hospital four weeks from the date of the operation. She had been free from pain and all signs of disease for over a year, but two months ago the growth reappeared in the cicatrix, and she is now in about the same physical condition as at the time of the operation.

CASE III.—Mrs. S——, a widow, of this city, has been under my care for twelve years. At the time of the operation she was seventy-two years of age, had cirrhotic kidneys, mitral regurgitation, and prolapsus. From time to time the prolapsus developed erosions of the cervix, which had always yielded to appropriate treatment. Last October she again applied for relief, but the usual remedies failed to

afford her any benefit whatever. A portion of the diseased tissue was removed, and a careful microscopic examination showed it to be cancerous.

Dr. West of Geneseo, N. Y., the patient's son-in-law, was called in counsel, and vaginal extirpation of the uterus was decided upon, with no small degree of misgivings for the success of the operation.

She entered the Rochester Homœopathic Hospital, and on the 13th of February I removed the uterus per vaginam in fifteen minutes. Even with this short operation there was considerable shock, from which it took her fully twenty-four hours to react.

All of the large vessels were secured with the clamps, which were applied to both broad ligaments, without inverting the uterus. The organ was then cut away with scissors, and the vagina protected with gauze wrapped about the clamps. The dressings were applied and retained by a T bandage. Her recovery was remarkably even, and she remains well.

CASE IV.—Mrs. A. S.,— fifty-five years of age, married, and in good physical condition. Cancer of the cervix was well marked and the diagnosis verified by microscopic examination. Her physician, Dr. McPherson of Palmyra, advised vaginal hysterectomy, and the operation, which lasted twenty-five minutes, was performed at the Rochester Homœopathic Hospital, December 12, 1889. There was no shock; the highest temperature was  $100\frac{1}{2}^{\circ}$ , and she recovered sufficiently to return home in three weeks.

CASE V.—Cancer, complicated by papillomata of the pelvic peritoneum.

Mrs. E. B.,— sixty-two years of age, is the widow of a late prominent physician.

Dr. McPherson of Palmyra, in sending this his third patient to me within a few weeks of each other, said he hoped I would not think he had a special method of devel-

opment of this disease. Be this as it may, he was always accurate in diagnosis, and sound in treatment.

Although there was well-marked carcinoma of the uterus, the patient seemed to be more feeble and anæmic than would be usual in the early stage of malignant disease.

January 18, 1890, vaginal extirpation of the uterus was performed at the Homœopathic Hospital. When the tissues were cut through posteriorly a quart or more of water poured out of the vagina. For a moment some of the assistants believed that I had cut into a well-filled bladder, but on passing my fingers into the pelvic cavity I found that the somewhat thickened peritoneum was studded with papillomata. Drainage was established, and the patient made a good recovery.

At the time of writing, five months since the operation, apparently there is no return either of the papillomata or cancer.

CASE VI.—Mrs. — of Fort Edwards, N. Y., was operated upon at her home, February 10, 1890. She made a remarkably good recovery, but as Dr. M. W. Van Denburgh wishes to report the case, I omit it here.

CASE VII.—Mrs. F, — married, forty-one years of age, and the mother of three children. In her case, like several of the others, a family history of cancer could not be elicited, yet she had suffered from carcinoma of the uterus for two years. During this time she had several hæmorrhages and a fetid vaginal discharge which greatly reduced her strength. The uterus was movable to a considerable extent, yet it could not be drawn well down. The mucous membrane of the vagina was divided with scissors, and the dissection up to the peritoneum, anterior and posterior to the uterus, was chiefly made with the fingers. Atlee's uterine dilator was passed through the peritoneum, the blades separated, and the fingers made to enter the peritoneal cavity between them. The peritoneum was then torn from the uterus, and Greig Smith's clamps, as modified by

me, applied to the broad ligaments, and the uterus cut away without inverting the organ. There was more obstinate oozing than I had ever before seen. The wound was packed with gauze, which, with the clamps, was allowed to remain two days. There probably was some infection of the wound during the operation, as the temperature reached  $103\frac{1}{2}^{\circ}$  for three evenings, and averaged  $101^{\circ}$  for two weeks after the operation. With this exception she made a good recovery, and left the hospital four weeks from the date of the operation, in better flesh and general condition than when she entered the institution.

CASE VIII.—Mrs. W——, married, thirty-eight years of age; mother of two children; slender build; has been in poor health for three years.

Carcinoma of the uterus developed three months ago, progressed rapidly, and involved the posterior portion of the cervix to a point on a level with the internal os.

Vaginal hysterectomy was performed May 5, 1890. The posterior lip of the uterus would not hold the vulsella forceps. This, together with adhesions between the rectum and uterus to a point as high as the fundus, made the operation, which lasted fifty-five minutes, very difficult. On entering the peritoneal cavity from behind, several ounces of old clotted blood and serum escaped, evidently from an old hæmatocele. Her recovery was remarkably satisfactory; there were absolutely no bad symptoms, and the average temperature was  $99\frac{3}{4}^{\circ}$ . She left the hospital four weeks from the date of the operation, apparently in sound health.

I have briefly presented the complications and accidents met with in these cases, chiefly to illustrate the use of a valuable aid in the rapid performance of this difficult operation. I refer to the Greig Smith broad ligament clamps. I imported these instruments from Weiss of London about two years ago, and will give the description of them in the author's own language:

"The instrument is simply a straight clamp with long and powerful handles, and grooves on its lateral aspect to guide a small knife which is intended to cut through the clamped ligaments. It is deeply slotted on its compressing aspect, to prevent slipping; elsewhere it is smooth and rounded. Through the posterior opening the forefinger is carried over the top of one broad ligament, hooking it down as far as possible. This maneuver may be facilitated by a blunt hook, handed over to an assistant. The posterior blade is now carried upwards along the finger, at a distance of about half an inch from the uterus, and the end hooked over the top of the ligament. Its handle is pressed backward on the perineum. The anterior blade is introduced in front of the ligament, parallel to the posterior blade, and its end is locked by a simple mechanism into the end of the posterior blade. The clamp is then closed, and the handles screwed up tightly outside the vulva. A second clamp is similarly applied on the opposite ligament. When both clamps are applied, the knife is run up the grooves and the ligaments divided on the uterine side of the clamps, when the uterus is freed; or scissors may be used for this division. The instruments may be easily removed at the end of two or three days, when the natural process of vascular closure will provide against the occurrence of hæmorrhage.

"The use of these instruments renders the operation a very simple one. It is possible, in the deadhouse, to remove the uterus by means of them in five minutes, and leave the parts in a condition anatomically and surgically satisfactory; and on the operating table, the proceeding ought not to occupy more than a quarter of an hour."

I have not been able to complete the operation as quickly as the author says it ought to be done, except in one instance; but I believe this was generally due to defects in the instruments, or serious complications.

In several of these cases the clamps slipped off from the

ligaments immediately after the uterus was cut away; this gave rise to dangerous hæmorrhage, which was exceedingly difficult to control. I also found that the sliding knives could not be run up the grooves without danger of their slipping too far and thus wounding the intestines or other tissues. To remedy these two serious defects I had Messrs. Tiemann & Co., of New York, modify the instruments. The old friction joints were exchanged for the French lock, which renders slipping impossible, and a stop was placed over the grooves so that the knives cannot be pushed beyond a point of absolute safety.

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## NERVOUS DERANGEMENTS PRODUCED BY SEXUAL IRREGULARITIES IN BOYS.\*

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BY

WILLIAM D. GENTRY, M.D.

ROGERS PARK, ILL.

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When the fact is considered, as it has been established by indubitable evidence within the past few years, that more than one-half of all the criminals incarcerated in the penitentiaries of our country are afflicted with abnormality of the genital organs, it is time for us, as physicians, to diligently inquire into the matter.

Had the fact that the assassin and despicable crank, Guiteau, who murdered the lamented Garfield, was possessed of an adherent prepuce, anything to do with his being a criminal? Has the fact that other criminals who have phimosis, adherent prepuce, or other deviations of the generative apparatus, anything to do with their being criminals.

The assistant superintendent of one of the largest lunatic

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\* Read before the American Institute of Homœopathy, session 1890.

asylums in the United States told me last week that more than one-half of all the inmates afflicted with lunacy or mania in the asylum had some abnormality of the sexual organs, the females with uterine diseases or deviations, and the men with phimosis or some other irregularity of the genitals. Has this fact anything to do with their being lunatics or having mania?

For one, I am prepared to take the position that such is the case,—and maintain that a majority of cranks, hobby-riders, criminals, and those affected with nervous disorders or diseases, are made so by or in consequence of the neglect, ignorance, or failure of their physicians or mothers at the time of their birth, or during the years of their infancy.

Go along the streets of any of our large cities, or small cities or towns, either, as to that matter, and you will be astonished at the number of boys or men you meet who are cripples, or presenting in their countenance or demeanor evidences of some nervous disorder.

My attention was called to this important subject many years ago, and I tell you I was perfectly astonished and horrified at the result of my investigations; and now, in behalf of humanity, wishing to improve the condition of my race as much as possible, I present the history of a number of such cases treated by me, and appeal to my professional brethren throughout the world to pay some attention to the matter, and in future be the means of saving the world from so much trouble, shame, and suffering.

The first case to report, is that of a boy my attention and sympathies were attracted to, whom I observed limping along the street. His right arm and leg were three-quarters of an inch shorter than the left. The right hand was drawn downward and backward, making a bow at the wrist. He could not use the right hand, and everything he attempted to hold with his left would fall. His mother had to feed him. His tongue was drawn to the right, and on account of its paralyzed condition he could not speak plainly. He

could not attend school on account of his inability to study, or control his actions. He was eleven years of age, but did not look to be more than seven. I asked him what was the trouble. He said the doctors had been treating him for St. Vitus's dance. I saw that he was a very poor boy, as he was trying to sell papers, and was dressed shabbily. I therefore felt more free to interest myself in him. I told him that I was a physician, and that I did not think his only trouble was St. Vitus's dance, and that if his mother would come with him to see me I would like to talk to her about the case. The boy and his mother called upon me the next day, and to her great surprise I showed her the cause of the chorea and paralysis to be phimosis. The prepuce was firmly adherent to the glans, leaving the orifice about the size of a number one catheter; urination being difficult, slow, and frequent. In his infancy he was healthy and vigorous, and nothing was noticed wrong with the boy until he reached his fifth year; then he commenced showing signs of some nervous disease, the trouble assuming the character of chorea. His mother knew nothing about the care of a boy baby, and her physician failed to explain to her the necessity of keeping the parts clean. When he was taken to physicians for treatment, they did not think of ascertaining and treating the cause, but treated the effect, and of course failed. The next day I operated by dissecting and amputating the prepuce as far back as the corona glandis. The wound healed in seven or eight days, and the boy was allowed to take out-door exercise. This was in September, 1885. He was directed to exercise his arm and leg twice every day by massage and movement. In one month's time the boy commenced to show signs of having better use of his limbs and tongue. In six months he was able to use his right hand in eating, and in one year he had recovered entire use of both his limbs, and could talk as plainly as any boy. In two years his limbs were of equal length, and he had grown to be as large and tall as boys of



his age. He was saved from a life of helplessness and misery, and is now, five years after the operation, a bright, intelligent young man.

CASE II.—Freddie F——, aged twelve. I was called to see this boy one cold night in February, 1886. He had just recovered consciousness from an attack of epilepsy. On inquiry it was learned that he had been subject to these attacks every few weeks for seven years, and had been treated by a number of prominent physicians, who thought that the spasms were caused by worms, constipation, malaria, or some spinal trouble; and he had been treated for all these.

The boy, although twelve years old, looked to be no more than eight. Besides he had a dwarfish, "old-man" appearance. He was nervous and restless; his sleep was disturbed; he was far behind at school, and was unable to grasp ideas suited to boys of his age. As soon as I saw the boy and heard the statement of his trouble I was convinced that it was caused by some irregularity of the sexual organs. The parents were astonished when I made known to them my opinion. They said they had never noticed anything wrong; that they had employed the very best talent, and the boy had been treated for the epilepsy for years, and nothing of the kind had ever been hinted at by any physician before. They could not believe that such trouble would cause epilepsy, anyway. I told them of my experience in other cases of the kind, and finally obtained their sanction to make an examination. The parents were dumfounded when I showed them that the prepuce was completely and firmly attached to the glands, so much so that the meatus urinarius was hidden from view, and the prepuce so contracted that it was with difficulty a small-sized pocket probe could be introduced. The father knowing that the part was not right, and as I was so positive that the epilepsy and other nervous derangements were caused by it, readily consented for the operation. I operated the next day.

In one month's time the boy exhibited signs of improvement in his general health and appearance. He had but two spasms after the operation, and now, four years and more after, he is well and hearty; is equal to any boy of his age in intellect and ability to learn, with every promise of making a first-class man. Ignorance upon the part of the mother, not having been informed how to care for her son by her physician at the time of his birth, caused the trouble; and ignorance or unthoughtfulness on the part of the physicians after he was afflicted, caused it to continue.

CASE III.—Whilst I was physician to the Children's Home at Kansas City, in 1884-5, there was brought to the Home, from some similar institution in Chicago, a child two and a half years old, who was blind, deaf, and dumb. It was nervous, fretful, and caused the matron a great deal of trouble. It was dwarfed, and presented the peculiar general appearance which nearly every boy will present who is afflicted with sexual derangement. As soon as I saw the child the thought came into my mind that his trouble had some connection with such derangement, and on making an examination, found that he had phimosis. With the consent of the father of the boy, I operated, and removed the derangement. In two months the child could see and make sounds as if trying to speak. In six months he could hear, see, and speak.

CASE IV.—Frankie W——, aged seventeen, but having the appearance of being no more than eleven or twelve; dwarfed; imperfect, lisping speech; locomotor ataxy, with considerable incoördination, so much so that he could not walk straight without assistance; restless, and most of the time unable to sleep; irritable; unable to attend school or study; vicious; appetite poor; constipated. Took no interest in anything, except wickedness. I at once attributed the cause of his trouble to the sexual organs. Upon examination I found that they, like himself, were dwarfed. Their cleansing had evidently been neglected since his

birth. Matter and hardened lumps of smegma had accumulated between the prepuce and the glans, and behind the corona glandis. The lumps were hard and solid as clay baked in the sun. There were no adhesions, nor any evidence of phimosis, but there was irritation, and considerable chronic inflammation. The parts were cleansed, leaving the appearance of a raw piece of beef. I sprinkled some Hydr. 1-2x trit. upon the inflamed surface, and gave Nux v. 3x every four hours, and placing the negative to his feet, I applied the positive to his spine, manipulating his forehead, neck, and spine with a faradic current every two and three days for three months, when he was quite well. He commenced to improve within two weeks after the first treatment, and in one month was able to speak so that he could be understood, and walk without assistance. In one year his growth was marvelous, and he had attained the full stature of a man. He became a close student, and took interest in everything.

CASE V.—A little boy, three years of age, could not utter a word without stuttering. The distressing trouble had existed for six months. I found, on account of neglect, the smegma had accumulated, and that inflammation had ensued, causing adhesion of the prepuce to the cervix and glans, where it reflects over the corona glandis. This adhesion was removed, and kept oiled with calendulated vaseline, until well. In two months the patient ceased stuttering, to the great delight of his parents.

Cases VI., VII., and VIII. are similar to the last: completely cured of stammering by removal of sexual deviation.

CASE IX.—Boy three years old. Has had enuresis all his life, and now presents unmistakable symptoms of talipes spuria. His parents are greatly alarmed at his condition, as in walking he suddenly falls to the ground, on account of the weakness of his ankles. I found he had phimosis. Operated and removed the trouble. Now three months have elapsed, and the boy is well of enuresis, and his ankles

much stronger, and his feet straight. The boy, dull and heavy in his movements and manner before, now is lively and playful.

CASE X.—Louis B——, seven years old, is far smaller in every way than he should be. Has been puny and sickly since infancy. His heart beats very slow, and whenever he makes any exertion has a tumultuous movement. It is certain he cannot live very long without something is done for him. On account of his nervousness, irritability, and peevishness, and general appearance, I am led to suspect the cause: sexual irregularity. On examination I find an adherent prepuce. In one month after operation there are unmistakable symptoms of improvement. His heart beats stronger and regularly, and he is not so peevish. He also had enuresis, which has already disappeared.

Many other cases could be given representing a large variety of diseased conditions caused by sexual irregularities in boys, but time prevents me from giving them now. A sufficient number has been given, I hope, to awaken a renewed interest in the subject, and to establish the importance of physicians and obstetricians giving proper instructions to mothers at or soon after the birth of boy babies.

When a physician is called upon to treat a boy or young man suffering with any of the following conditions: stunted growth; unhealthy, "old-man" look; nervous derangement of any kind, such as incontinence of urine, sleeplessness, chorea, spasmodic neuralgia, neuresthenia or nervous prostration, recurring convulsions, epilepsy, defective articulation, squinting, jactitations, paralysis, locomotor ataxy, incoördination, and similar troubles, he should look toward the generative organs as the seat of the trouble, which by reflex action produces the effect. Either phimosis, adhesion of the prepuce to the glans penis, or irritation of the parts, will result in producing any of the above mentioned, besides other nervous, physical, or mental derangements, because the genitals of either male or female are the cen-

ters of the nervous system, and any diseased condition there will nearly always result in some nervous, physical, or mental affliction.

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## PUERPERAL ECLAMPSIA.\*

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BY

O. S. RUNNELS, M.D.,  
INDIANAPOLIS.

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To shine or burst forth suddenly, to come as thunder from a clear sky—or as the leap of a tiger upon the back of an unwary traveler—this is eclampsia; a condition full of the most adverse and calamitous experiences that can come to the pregnant; a disease that steals upon its victim usually without attracting notice, and precipitates her into a vortex of most appalling danger. The frightful havoc that accompanies puerperal eclampsia can be grossly realized when it is known that over 33 per cent. of the mothers and over 50 per cent. of the children are sacrificed in a few short hours after the terrifying onset of the disease; and that the maternal mortality is further augmented by affections which follow as legitimate sequelæ of the eclamptic condition.

It is now established that about one in every three hundred pregnant women have puerperal convulsions, and that of all those attacked 77 per cent. are primiparæ—the most unwary, the least experienced.

Eclampsia may occur during any month of gestation, but usually appears toward the last of the term. While it most generally accompanies labor—hastening that event and ceasing with delivery—in many cases the convulsions continue after the birth or even make their first appearance

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\* Read before the Missouri Institute of Homœopathy, April 23, 1890.

then. These post-labor attacks, however, may be delayed for hours or days. Bailly, Simpson, and Baudelocque had cases twenty-nine, twenty-eight, and thirty-six days, respectively, after delivery. The post-delivery attacks are as a rule less malignant than those occurring during labor; while those which precede and continue after labor are the most dangerous.

But while nothing in disease manifestation is more sudden and appalling than puerperal convulsions, it is exceedingly doubtful if they ever come unheralded. To the watchful observer signals appear which tell unmistakably of the approach of this physical storm. To detect these at their onset, and to deal with them in accordance with their demands, is at once both the golden privilege and the imperative duty of all who have charge of pregnant women.

To emphasize these symptoms that give first warning, and to point out the remedies to combat them successfully—rather than to embody an exhaustive article on the subject—is the object of this paper.

The three symptoms which fortell eclampsia are *headache*, *disturbance of vision*, and *epigastric pain*.

*The headache* is pathognomonic. It is usually frontal, sometimes lateral, but rarely is it occipital or general. At first this pain is not constant—remits or intermits; but if continuous the attack may be expected at any moment. Usually this headache precedes the outburst by several days or weeks, and is accompanied by mental dullness or apathy.

*Visual interference* is not so constant a symptom as cephalalgia, but when present is strongly corroborative. The sight may be only indistinct or weakened; she can not use the eyes for any length of time without paining or fatiguing them, or there may be amblyopia or amaurosis even. One fatal case, in the fourth month of gestation, is recorded where almost total blindness was present for two days before the seizure.

*Epigastric pain* is less constant than either of the two symptoms just considered, but if present is often the most urgent feature. The patient cries out or groans with the suffering, and throws the body forward or to one side to get relief. In one of my cases this pain was in the dorsal vertebræ and so intense as to cause the greatest agony.

Accompanying these phenomena are other symptoms very characteristic, such as: dizziness, mental depression or melancholy, stertorous breathing while asleep, œdema of face, particularly about the eyes upon arising in the morning, nausea and vomiting, constipation, together with a noticeably scanty secretion of urine, generally highly albuminous. Unfortunately physicians are not usually consulted till these symptoms, one or many of them, have progressed for days or weeks,—until, in fact, the “crack of doom” is at hand; and the disaster is ten-fold more difficult to avert.

To prevent this inattention on the part of the patient or her guardians, the physician, upon his first acceptance of such a case—whenever he becomes aware that his services as accoucheur are expected, and particularly with primiparæ—should instruct those concerned to look out for the *Big-three Symptoms* before referred to, and to report without delay if they, or any semblance of them, should appear.

What are the causes that can lead to such an exhibition, and what are the best means to abate them? After long discussion and experimentation it is well settled that eclamptic like epileptic convulsions do not depend upon a single cause. Until quite recently it was believed that the cause was traceable in every instance to renal insufficiency. The urine being scanty and highly albuminous, the constituents of the urine—urea, creatin, creatinine, etc., were thrown back upon the system, rendering the blood “urinæmic,” and thus through toxic influences producing irritation of nerve-centers, leading to convulsions. The cause of the *renal insufficiency* was argued to be mechanical pressure of the

gravid uterus upon the ureters and renal pelvi, thus preventing the normal secretion and excretion of the urine. This mal-condition is further aggravated by bodily inaction—the sedentary habit and constipation so often found among the pregnant. Some cases of deficient excretion have been proven to be mere retention, the foetal body pressing upon the vesical cervix prevents micturition and enormously distends the bladder. Several instances are recorded where a catheter effected a speedy cure after other well-indicated remedies had failed.

But some cases give no evidence of renal complication—the urine failing to give the least abnormal trace. Even if somewhat deficient in quantity the quality is normal. At the same time *albumen* is found in the urine of many women in gestation who complete the time without showing any eclamptic tendencies. It is said that one pregnant woman in every five has albuminous urine. The very important deduction follows that the kidneys are often innocent of all blame in the causation of eclampsia. If a surcharged bladder may be the sole exciting cause, may not the disorder arise also from uterine irritation alone?

Remembering the profound impressions exhibited in “morning sickness,” one can readily understand how disturbances in the nutrition of the nerve-centers may go silently forward to a climax like this from irritations constantly acting upon the uterine nerves.

With these distinctions well in mind the treatment can be proceeded with more confidently.

The first inquiry should be directed to the emunctories. Is there proper evacuation of the bladder and bowels? Is the skin in the right condition for the performance of its functions? there should be no stasis in any of the excretory channels. The kidneys, bladder, bowel, and all the excretory ducts should be operative and active, the diet should be regulated and exercise established. Ordinarily the eclamptic patient is a heavy eater; is disinclined to exercise;



is constipated and lethargic. Her life-stream is flowing sluggishly—turbidly. The currents must be quickened and the elimination of the waste stuffs assured. This done by catheter, enema, cathartic, bath, sweat, or massage—the input lessened and the out-put hastened—the practitioner is in position to select the indicated remedy for her further treatment. But let no one content himself with the latter, till the former work has been satisfactorily done.

Hahnemann's golden rule, "Remove the causa occasionalis first," must be religiously followed; and not until this has been accomplished may we confidently expect satisfactory responses to our otherwise carefully selected remedies. The "similimum" must not be required to remove mountains, to act promptly in spite of impedimenta of such magnitude as to block the wheels of a locomotive. I will not detain you with the special indications that call for aconite, arsenicum, belladonna, bryonia, mercurius corrosivus, nux vomica, and veratrum viride. With the photographs of these drugs and others likely to be called for, you are or ought to be already familiar. When you have photographed the diseased condition you can then, and *not till then*, find its correspondent in the materia medica. Each case makes its own demand, and requires, together with its drug, careful individualization.

If time is granted I believe that every case can thus be conducted to a safe and pacific delivery. But this presupposes that the patient has had wise oversight; and that the physician has been notified upon the first erratic manifestation—certainly upon the advent of any member of the *big three*, before emphasized.

Unfortunately, however, the physician is usually kept in the background until the emergency is announced; until the time for deliberate action is well-nigh passed: until it is a *race for life*. In every such case the time for sleep has passed. The doctor, at least, must now be awake. He must at a glance take in the situation. The celerity of his

movements must be governed by the imminence or remoteness of peril. He must institute measures for the clearance of the emunctories. This according to the stress may call for a couple of drops of croton oil on the dorsum of the tongue; a corn-sweat, or quick evacuation of over-loaded stomach or bladder. The selected remedy must be put to test. If it be before the seventh month of gestation, uterine calm must for a time be favored; but if later, take prompt steps for the earliest emptying of the uterus. Meantime if the convulsion be not severe and if the heart is not being driven into very rapid action—*wait*. If, however, the progress be rapid; the convulsions increasing in frequency and severity; the heart growing more and more excitable, and the brain consequently more intensely surcharged with blood—the time has come for the employment of sedatives.

Convulsive action must be suspended till the time requisite for uterine evacuation be fulfilled. Practitioners there are who believe they can successfully convoy every such patient through such a maelstrom by the steady and observant use of chloroform. Planted at the bedside, and armed with this ruler of nerve-force, the patient is held *in statu quo* till the peccant matters, or the mechanical causes of the difficulty are removed from the system. The convulsion is not allowed to repeat itself. The heart is not permitted to be driven at a fatal rate; and thus is prevented that apoplectic distension of the vessels of the brain, with its accompanying destructive effusion so often seen, the ganglia are thus spared the pressure that will deprive them of all power to express themselves—i.e. paralysis.

Other agencies to accomplish the same end have been employed with encouraging results; such as rectal injections of chloral hydrate; full doses of opium or morphine, or ten-drop doses of tincture veratrum viride hypodermatically administered every fifteen minutes till the heart's action be slowed to a safe rate.

The rationale of this treatment consists in the suspension

of cerebro-spinal activity till certain irritants can be removed. Through the employment of sedatives an effort is made to regain time lost in long days and weeks of neglect. Under these circumstances sedatives hold the same relation—have just as valid a place among the armamentaria of the accoucheur—as do anæsthetics and the tourniquet among the weapons of the surgeon.

When we have accomplished an otherwise unattainable end, we can continue the use of the indicated remedy with the same propriety as we use *arnica hypericum* or *calendula* after bruises, concussions, and general surgery.

By timely aid thus afforded at the outset of this puerperal malady, the development of the disease into a frightful reality may be thwarted, while the rational management of the same after it has reached the cyclone stage may yet be so successful as to make a fatal termination a very rare exception.

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### THREE CASES OF AMENORRHŒA.\*

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BY

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CASE I.—Miss J. N——, thirty years old. Came to me Dec. 30, 1889. She said that she had not been unwell for six weeks. Menses began at thirteen years of age and were regular till her fifteenth year, then irregular. The last two years very irregular, the longest period being seven months, and never oftener than five weeks. The interval of seven months ended in April, 1889, when she consulted an allopath, who gave her electricity every day for fifteen days in succession, when there was a scanty flow for one day. She

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\* Read before the Mass. Surg. and Gyn. Society.

then received the electrical treatment twice a week up to October ; during this time had one period, which was nearly normal. In addition to the electricity she took a great deal of medicine : one kind looking very much like "ground-up lead pencil," to use her words. She was very much discouraged, and asked if I thought anything could be done. The patient was short and stout, dark complexioned, with a decided growth of hair on upper lip and chin, and I didn't think the outlook very brilliant.

On examination I found the uterus enlarged and congested, the cavity three inches deep. The cervix showed two or three eroded spots and was exquisitely sensitive. The menses had never been oftener than five weeks, as I said before ; the flow dark, profuse, clotted. On the first day pain in the sacral region, which runs up over the hips and down the thighs, nausea and vomiting, and the flow is very scant and light colored. On the second day the flow begins, is dark and clotted ; the flow lasts about seven days in all, and during that time she is inclined to faint.

Headache over the left eye, grows worse until the flow begins, not relieved or aggravated by anything as far as I could ascertain. No headache if menses regular.

Sleep good except just before a period, when she is very nervous and sleepless. This has occurred during the time of suppression, when the menses should have appeared. Appetite good ; bowels regular. Bearing-down feeling worse if tired, or when she wears corsets. Leucorrhœa only in the day, yellow, does not excoriate. Urine has a brick-dust sediment (on examination later was found full of urates).

As I was not satisfied to prescribe on the above symptoms I gave sac. lac. Jan. 3, 1890. Sleeps generally on the left side. Prefers cold to heat, but feels better indoors than out. Dull feeling in the head all the time, cold applications > and cause an eruption on forehead, somewhat relieved by heat : wants to lie down and keep very quiet.

Soreness of scalp on vertex follows headache. Wants to be working very hard all the time; nervous; fretful; inclined to melancholy, sympathy<. Dragging backache in sacral region, better from rest, worse any other way. Is worse in the evening. During the headache has a feeling as if the forehead opened and closed. Seems as if she slept into the headache, which grows worse during the day and is relieved by sleep next night. Feeling again that I ought to study up the case, I gave sac. lac.

Jan. 10, 1890.—All the additional symptoms I could elicit were that on the Sunday preceding she had a headache as above, over the left eye. Urine very offensive, and *the sediment sticks to the vessel*. Prescribed sepia 3x, night and morning.

Feb. 10, 1890.—She reported that on Jan. 15 she flowed profusely one day and then stopped, waited a week later (Jan. 22), and the catamenia returned, the flow being dark and profuse, with a great deal of bearing down and pain in the back. The leucorrhœa was very much better; headache better, but when she had one it was > by heat. Urine with scarcely any sediment. Constipation two or three days before the flow began. I continued the sepia 3x. Up to the present time (June 11) she reports three menstrual periods.

CASE II.—Miss B., thirty-four years old. This was a dispensary case.

Jan. 23, 1890.—She is about 5 feet 4 inches high; stout; dirty, muddy complexion. Amenorrhœa three months. Examination showed the uterus small, cavity about two inches deep; otherwise normal. Menses used to come every twenty-eight days; flow three days, dark; thick, greenish leucorrhœa, more before the menses. Neuralgia in the temples < *in the evening*: takes "pills" to move the bowels, which are very constipated; the leucorrhœa does not excoriate. Puls. 3x.

Jan. 30, 1890.—Leucorrhœa better, also the neuralgia and

constipation; complains of beating in the vertex and temples, < when the menses should have appeared, and in the evening. Puls. 3x.

Feb. 6, 1890.—Headache and bowels both better, otherwise no change. Puls. 3x.

Feb. 13, 1890.—Constipation nearly as bad as at first; inclined to be chilly all the time. "Fat, cold, constipated." Graph. 6x.

Feb. 20, 1890.—Symptoms the same as last time. Graph. 6x.

March 5, 1890.—Feet inclined to be cold; appetite very poor; very thirsty; constipation; no urging or inclination for stool; urine without sediment, perfectly clear, light colored. Sulph. 3x.

March 20, 1890.—Menses came on two weeks ago tomorrow (two days after the last prescription). Flow scant, dark, a few clots. Sulph. 3x.

April 10, 1890.—Should have been unwell last Friday (April 4), but there was only a show then. Bowels are very regular; headache generally on the left side, < out doors. Sulph. 3x.

April 24, 1890.—Constipation troubles her again; stools very hard to pass; feels generally the same as last time. Sulph. 3x.

May 15, 1890.—Menses came on three weeks ago tomorrow (April 25); flow more than ever, no pain, color dark; bowels are very regular now. Sulph. 3x.

The patient is well up to the present time (June 11), and has had one period since the last prescription.

CASE III.—Miss H. L.—, twenty-one years old.

April 20, 1890.—Patient was of medium height, inclined to be stout, dark hair and eyes, red cheeks, *very* red lips, clear complexion. She said it would be eleven weeks next Wednesday (this was Sunday) since she was unwell; previous to that menses every three weeks; used five or six napkins; flow dark; scant (?); dull pain in hypogastrium

before ; no pain after the flow began. *Always hungry at 11 A.M.* (but on inquiry found she ate very little breakfast) ; *is very thirsty* ; appetite good for dinner and supper ; constipation with no inclination for stool ; thinks she got her feet wet ; nausea in the morning on rising > by a drink of cold water (she has had this symptom for three or four years). Sleep very good ; bad taste in mouth on waking in the morning ; tongue red at tip and yellow in center. Thought she was going to be unwell about a month ago ; menses were never suppressed before ; began to menstruate when fourteen years old. I told her to report in a week and gave sulph. 3x.

April 27, 1890.—Appetite better and is not hungry at 11 A.M. ; bowels regular now ; not thirsty in the morning now, but is through the day ; no nausea ; complains of leucorrhœa, < in the morning ; sometimes when the catamenia should appear, the leucorrhœa is so bad it makes her think she is unwell ; lips still very red ; tongue cleaner. Continued sulph. 3x.

May 8, 1890.—She complained of frontal headache *on waking* ; > after breakfast and while working around the house, especially if the windows are open ; has had this for five days. Last night it was very bad at 9 P.M. in addition to the other aggravation ; > *from eating and walking in the open air* ; appetite good ; wakes at 3.30–4 A.M. and can't go to sleep again ; there is great soreness or heaviness in the head all the time ; bowels very constipated the last two or three days. Puls. 4x.

May 18, 1890.—Reported that she was unwell five days after receiving the last prescription ; amount and color normal. I made no examination in this case.

In these cases the medicine was not taken oftener than three times a day and sometimes only once.

## CLINICAL OBSERVATIONS BASED ON OVER FOUR HUNDRED ABDOMINAL SECTIONS.\*

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BY

R. LUDLAM, M.D.,

CHICAGO.

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If "keeping a diary will add a new terror to death," perhaps one should desist from relating his professional experience in the manner that is proposed in this paper. And yet, considering the times upon which we are fallen, and how very rapidly we are making history, special surgical history, in these latter days, it may be a duty and a privilege to make note of what we have seen and learned through a somewhat lengthy and unusual career.

This contribution, which is offered to the Clinical Society in good faith, is based upon more than four hundred abdominal sections that have been made by the author during the years 1872-1890. Beginning at a period when peritoneal surgery was imperfectly developed, many of these operations were performed under the most trying and adverse conditions, and with a technique that was neither aseptic nor satisfactory. At first there was such a well-founded prejudice against making an ovariectomy, or incising the peritoneum for any purpose in a general hospital (and special hospitals were few and far between), that we were forced to take to the field and to operate in the homes of our patients. In that way, and for that reason, I have opened the abdominal cavity of my patients at their residence in fourteen of the different States of the Union. Of late years, since the safeguards are what they should be, and the risks are decreasing in a wonderful ratio, I have also operated in eight different hospitals; and most of the

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\* Presented to the Clinical Society of the Hahnemann Hospital, Chicago.



members of the Society have been present at one or more of my clinics in which an abdominal section has been made. These facts are stated because the validity of one's professional experience depends upon his opportunities, as well as upon his capacity for observation and improvement, and his honesty in making up the record.

I.—*Of the house-to-house as compared with the hospital methods in abdominal surgery.*—There are advantages and disadvantages in both of these methods. I am satisfied that there are women whose chances of recovery from an ovariectomy will, other things equal or nearly so, be the better for having it done at home. This class includes those who are extremely sensitive; who have a mortal dread of going to a hospital, lest they should not escape with their life, and of being placed or left among strangers; who, with or without reason, worship their own doctors, and who cannot place implicit confidence in anybody else; who, in old and neglected cases, are too weak to travel a long distance, even in the sleeping-coach or the parlor-car, and whose family bonds and sympathies are so strong that a forced separation would materially lessen the chances of their getting well.

While many and perhaps most highly neurotic women should be removed to new and strange quarters before an abdominal operation is made, there are exceptional cases of this kind in which a laparotomy for any purpose had better be done at home. For, while, as a rule, the new conditions will tend to fortify the patient's mind and body, it nevertheless may happen that the strain induced by them will be so great as to balance matters the wrong way. It is quite possible, I think, that this, among other causes yet to be considered, may account for the increased and increasing frequency of psychical disorders after ovariectomy. In November, 1882, I removed a thirty-four pound tumor from a woman who was ill with a form of insanity for which she had been kept in an asylum for a year. The operation was

made at her home, where, with the kind care and sympathy of her husband and her physician, she made a good recovery. Her mind was soon restored, and she has since born two beautiful children into the household, over which she continues to preside with dignity and character. I am persuaded that if the operation had been made elsewhere the result would have been different.

These little matters, which of late are not always considered, do, sometimes, weigh in favor of the home-plan. If the patient's residence is not too old and dirty or neglected, and its internal sanitary conditions are what they should be, with good air and plenty of it around and within the building, and if her circumstances will command the proper nursing and professional care, without any social nuisance or interference, her own preference may be regarded and should be respected.

In quite a number of my cases the parties concerned have rented a house or rooms in a village, and so have brought the patient from the country to the town, where she would be within easy reach of my friend, the local doctor, who had charge of the after-treatment. When I went to California to operate in March, 1888, one husband bought a house and another rented one in Santa Ana for this express purpose, and through the excellent after-care of Dr. Will-ella Howe, both patients recovered. One of my most successful ovariectomies was made in a room directly over a noisy, dirty blacksmith shop; another, and a desperate one, too, in an Irish shanty below the sidewalk, on Quincy Street; a third, and one of the most unpromising that anybody ever had, in a room immediately over a neglected cistern. Under the care of Dr. C. N. Hazelton of Morrison, Ill., the last of these had the benefit of the aseptic treatment, but the others had nothing of the kind.

These and similar experiences show that good results are possible outside of the special hospitals, which it has been claimed are indispensable to success, and that if, for any

reason, recourse cannot be had to them, we may do well to operate elsewhere, the same as in laparotomy for gun-shot wounds, in cholecystotomy, nephrectomy, etc.

The simple fact is, that while it may not always be best that this or any other operation should be made in the patient's house rather than in the hospital, if a home is really fit to live in, or to die in, it is as fit *per se* as any other place for this kind of work. Or if it is not already so, it can very easily be made so.

Given the proper sanitary conditions that every good home, as well as every good hospital, should possess, the choice will turn (1) upon the possibility of exempting the patient from other and added risks of infection ; (2) of having the proper skill at hand for emergencies, and (3) of obtaining the good nursing and care which are so requisite, and which are promised, but are not always furnished in the hospital. If the family physician is treating all kinds of cases, and comes to one of these patients, whose abdomen has been opened, direct from those who are down with infectious diseases ; or if he knows but little and cares less about the modern gospel of cleanliness and asepsis as applied to surgery in the care of the drainage tube and the dressing of the wound, the chances are against recovery. If the patient's home is some miles away in the country and the roads are bad ; if the doctor has no office hours and no telephone ; or if, being obliged to be off on his rounds, nobody knows where he is when he is most urgently needed, the emergencies of the first week especially may cost the woman her life. If she must have a catch-nurse, who will not obey orders implicitly, or who, from a lack of experience or of good sense, has no resources of her own ; or even one who has been trained to do the right thing at the wrong time, or who is not truthful, or who is lazy and unsympathetic, it is far better that she should go to a good hospital where these disadvantages can usually be overcome.

But it should be remembered that these drawbacks to

recovery do not apply to the home-plan exclusively. There are physicians all over the country who are thoroughly competent to take the professional charge of the after-treatment in these cases. I am many times their debtor for what they have done for some of my patients. And there are many excellent and trustworthy nurses up and down the land who are endowed with a genius for taking care of these post-operative cases, although they may not be dressed in the conventional garb of the training-school graduate.

By the same token there are hospital physicians and nurses of the accidental sort who are not adapted, and who never can be, to this particular function. Such assistants will sometimes ruin the best work of the best operator, and spoil his record in spite of all that he can do. I have been very fortunate in this respect, and the possibility of such an obstacle is mentioned in this connection only because it is almost as likely to occur in the city as in the country, in the hospital, whether general or special, as in the well-ordered home.

The advantages of good hospitals are generally understood and conceded. They are, or should be, always ready for occupancy, sweet and clean, free from the germs of infection, whether these germs are latent, or if they are brought by the doctors, the attendants, or the visitors. They are, or should be, equipped with physicians and nurses of skill and experience, who are ready to do the best that can be done in a given case ; whose services will be available at all times, and who will be responsible for any neglect or oversight in the care of the patient. They are supposed to furnish the best and the most suitable food, and all the facilities for promoting the comfort and the convalescence of the woman who has survived the immediate operation. Indeed, they contract to prepare her for the ordeal, and to avert any avoidable mischief that might be lurking and serious but for this timely precaution.

All these and other requirements are more or less per-

fectly met by the modern hospitals which, thanks to a more general enlightenment, are being more fully and justly appreciated by the American people. And it is fitting that the women who have done so much for the building up of these charities should derive the greatest benefit from them when they are ill, and in need of our special services.

2. *Of private as compared with public hospitals in the matter of peritoneal surgery.*—Granting that in the great majority of cases it is expedient, it is best for the patient, who is about to undergo an operation which requires that the abdomen shall be opened should be taken to a hospital, it will still be a question whether that operation should be made in a general or in a special hospital. And this is a question that physicians in the country as well as in the city should be prepared to answer intelligently.

When there were no special hospitals for women, and no private hospitals of any sort that were reputable, these patients either had to be taken care of at their own homes, or in a public institution in which all kinds of cases, excepting the eruptive fevers, were treated. There was no alternative. And it is too easily forgotten that the first Woman's Hospital in America (1855) was not established for abdominal work, but for the repair of the vagina and the perineum, and for the more ordinary operations in uterine surgery that were coming into vogue at the time. The animosity and resistance that prevented Baker Brown from making an ovariectomy in St. Mary's Hospital, London, drove him with others to establish a small special hospital, the London Home for the Surgical Diseases of Women, in 1858. But it took care of three cases of vesico and recto vaginal fistulæ to one of ovarian tumor.\*

I am not aware that this state of things has changed in the matter of separating the cases of peritoneal surgery from those which require plastic operations about and

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\* "A Page in the History of Ovariectomy in London," by T. W. Nunn, consulting surgeon to Middlesex Hospital, London. 1886.

within the vagina. If there is a hospital in this country that is wholly and exclusively devoted to intra-abdominal work I do not know where you would go to find it. Nor is it a reproach to have it so, for nothing is more natural than that these cases should be thrown together and treated under the same roof, by the same or different surgeons.

The point is, however, that when such extra-peritoneal cases are admitted into special hospitals the claim that such hospitals are kept exclusively for the performance of ovariectomy and hysterectomy falls to the ground. And the same is true in a large sense of all those private hospitals in which the common and coarser kind of surgical work is also done.

Practically, therefore, these special hospitals for women are general hospitals on a smaller scale. The patients are grouped because they have some points of clinical resemblance, but their being classified does not give them any special immunity from the ordinary risks to which all patients of whatever sort who are operated upon are exposed. The common enemy of surgical infection threatens them all alike. The seeds of sepsis and of pyæmia coming from a bad wound along the linea alba may be as poisonous and as harmful to another woman who undergoes an abdominal section as if they came from a rotten stump or the puerperal uterus. The truth is that the patient's safety does not depend upon the mere fact that such an operation is made in a woman's hospital, in which there is of necessity a greater or less variety of surgical cases, but upon a compliance with certain conditions that are essential to success, wherever or by whomsoever it is made.

It is the possibility of meeting these requirements that makes any home, or any hospital, a safe place in which to perform ovariectomy or hysterectomy. And the greater the difficulty of bringing the building and the surroundings into a proper hygienic state, and of keeping them there, the greater the danger in any case of peritoneal section what-

ever. For the safety of the patient and the success of this kind of work depends, as we have learned from experience, upon a rigid system of surgical cleanliness in every detail of the operation, combined with skill and experience on the part of the operator.

Considering that these conditions are requisite and are of primary importance, the choice between public and private hospitals is, therefore, less important than it was a very few years ago. Nearly all the special hospitals for women in this and foreign countries, hospitals that are devoted to gynæcological surgery exclusively, are located in buildings that were formerly occupied as private residences. They have been cleansed, repaired, and made as healthy as possible, but, with very few exceptions, they are no better than most of our private houses and all of our newer hospitals would be if they too were kept in a proper sanitary condition and were not overcrowded.

Somebody has said that a clinical teacher is one who is engaged in "looking for the best side of bad facts." We are not searching for anything of the kind when we call attention to the fact that just as good work has been, and is now being done, in abdominal surgery in the general as in the special hospitals. Keith made his best record in the Royal Infirmary of Edinburgh, while Péan in the St. Louis, and Terrillon in the Salpêtrière of Paris, and many others at home and abroad are having the best possible results in the newer and larger hospitals in which all kinds of cases excepting the most pronounced infectious diseases are treated.

It has often been urged that private hospitals are the only suitable places for abdominal surgery because the relative mortality in them is not so great as in the public hospitals. There are two reasons for this statement, which has been more largely true in the past than it is at present, or ever can be again: (1) Some of the general hospitals were slow to adopt the modern surgical methods of asepsis

and absolute cleanliness, but persisted in working on the old lines and in the old buildings that were infected ; and (2) most of the women who are operated upon in private hospitals are of the better class, have taken better care of themselves, and are therefore in better condition, not having allowed the disease to progress until the last moment before the operation was undertaken, while the opposite is true of not a few of the poor, neglected, and often abused cases that enter, or are thrust into the larger hospitals.

Briefly then, I am convinced that, with the same class of patients, under the same sanitary conditions, with the same surgical skill and care in operating, and the same good nursing afterward,—conditions that under the new *régime* are available almost anywhere,—there is no good reason why an ovariectomy or a hysterectomy may not be as safely made in a general as in a special hospital. In the very nature of things abdominal surgery must always remain more or less distinct from that of other parts of the body, but it can be done by responsible specialists in public as well as in private hospitals if only they will keep the surgical commandments.

3. *The choice of anæsthetic.*—Both directly and indirectly this is a matter of great importance. We have first to determine whether the patient can safely be brought under the influence of an anæsthetic and kept there until the close of the operation. Then we must decide between ether and chloroform, or if they shall be given in combination ; and finally, what is quite as important, we must select the one that will give the least trouble during the after-treatment.

Fortunately, although as Fenwick has shown the heart-muscle is likely to undergo a structural change in the case of large tumors within the abdomen, it does not very often happen that such a lesion will interfere with a careful resort to anæsthesia. And yet in old subjects, more especially in those who have once suffered from rheumatism, and where there are cystic tumors involving both ovaries, the greatest caution is necessary. Bearing these facts in mind



I have only had two cases of this kind that turned out badly. One of them was a patient of Dr. T. C. Duncan of this city, who had had chronic cardiac disease with asthma, and upon whom I operated under protest for the removal of large cysts of both ovaries. Every precaution was taken, I had excellent and experienced assistants, and sulphuric ether was carefully given as an anæsthetic. The double operation was made in the usual way and was done quickly, both pedicles were tied securely, the peritoneum was not chilled, not more than two tablespoonfuls of blood were lost, the toilet of the peritoneum was perfect, and I was about to close the wound, when, without a struggle or warning of any kind, the heart stopped and it was impossible to resuscitate her. The other case was brought to my clinic by our friend Dr. H. W. Roby of Topeka, Kansas. This also was a case of chronic cardiac involvement in which it was deemed best to make an exploratory incision in order to settle a question of abdominal diagnosis, and, if possible, to prolong her life by an operation. The section was to be made in the hospital before the class to whom I explained the risks of anæsthesia under the circumstances. Because of some old renal mischief it was thought best to give her chloroform instead of ether. This was being very carefully done in the ante-room, under the special charge of Dr. Roby and the house physician, when, having taken but two or three whiffs of the anæsthetic, with plenty of atmospheric air, she suddenly became cyanotic and ceased to breathe.

On the side of the kidneys, especially if the tumor is old and malignant, I have encountered more frequent and serious complications. In the case of uterine fibroids that are large, and that through a recurrent peritonitis are firmly anchored, the pressure upon the renal vessels and upon one or both the ureters may give rise to forms of nephritis that greatly increase the risk of anæsthesia by sulphuric ether especially. The rule being that suppurating cysts of the

ovary and suppurative peritonitis are associated with suppurative nephritis, I always abstain from giving ether in such cases. In some of these cases also there is a concurrent and perhaps a consequent bronchitis which contraindicates its employment.

Some years ago, when Dr. Emmett had not yet warned us to test the urine for albumen before making an ovariectomy, and to withhold the ether if we found it, I lost one case from the effects of ether in a woman who, I afterward learned, had had albuminuria for at least two years, and another, an old lady, from suffocative catarrh that was greatly and fatally aggravated by the same cause. All the other conditions were favorable to recovery, and in the light of more recent experience I really believe both of these patients would have gotten well if they had taken chloroform instead of ether. They lived for several days after the operation, but never fully recovered from the effects of the anæsthetic.

In regard to anæsthesia these are the only cases in my whole list that have caused serious trouble. Following the example of the best ovariatomists prior to 1880, I began with using sulphuric ether instead of chloroform. For the first ten years (1872-82) I employed it exclusively, not only in all of my peritoneal sections, but also in all, or nearly all of my plastic operations, such as perineorrhaphy, colporrhaphy, trachelorrhaphy, etc., etc., in hospital and in private practice. During all that time I was fully persuaded that chloroform was much more dangerous and much more likely to work mischief after the operation than ether; and so I preached and practiced accordingly. Finally, however, through operating so often in my clinic, where time was a more important consideration than the possible after-effects of the anæsthetic, I came to use the chloroform in most of my plastic work, and the result was that I became convinced that my former notions were wrong and untenable.

For the past eight years, in the great majority of cases,

I have employed chloroform in preference to ether, and I am satisfied that my results are better. It is more agreeable and rapid in its action, and the patient can more easily and safely be kept in that slighter degree of insensibility, which in abdominal surgery is quite sufficient, once we have gotten through the integument. Its use does away with any special anxiety concerning the condition of the kidneys and of the bronchial tubes, and even where the heart is crippled we can begin with chloroform, make the first incision and then give ether through the remainder of the operation. The effect of ether to stimulate the heart and to antidote the depressing influence of the chloroform should always be borne in mind. It is because we might need, in almost any case, to substitute the one for the other that I prefer not to give them in a mixed form. Let us have one thing at a time, and then we know what we are doing and where the patient is all the while.

Lawson Tait is quite right when he claims that the older patients bear chloroform better than ether, and also when he adds: "I am quite convinced that ether is a far more dangerous anæsthetic than chloroform on account of the bronchial irritations and of the retching and struggling to which it gives rise." It is the greater likelihood of retching and vomiting, which so strain the wound and hurt the patient after a laparotomy, that makes the ether the least desirable of the two. Of late my patients seldom suffer in this respect to any such degree as they formerly did.

*(To be continued.)*

## HOW SHALL WE BEST TREAT UTERINE FIBROMA?

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BY

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THE subject under consideration presents such a variety of conditions as to make it susceptible of much debate, after that period has passed when diagnosis of the offending growth has been made beyond the peradventure of doubt. The experience of many competent surgeons, in whose judgment our simple confidence might rest content, leads them to vary conscientiously in identical cases as to the better method to be employed in the efforts of removal of the abnormal growth, and in the restoration of the unhappy patient to her wonted health. Now then, we may naturally ask ourselves the question, are we of lesser opportunity and experience to decide so complex and debated a question to the satisfaction of ourselves or others, when our preceptors of thought and guidance in the gynæcological domain do not set for us definite lines of treatment in given cases? We are all aware, that to one variety of growth best belongs the use of internal remedies and drugs, and was so recommended, and advised by Marion Sims, while for the identical condition, Lawson Tait listens to nothing short of laparotomy and the extirpation of the ovaries and Fallopian tubes. Disagreement is further perpetuated by Keith, who, from his marvelous record of recoveries, has advised supra-vaginal hysterectomy in preference to any other plan; \* to all of which Schroeder negatively nods, and promises, with an equal degree of sincerity, that much better results

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\* Keith has lately shown a preference for the use of Apostoli's method in the place of hysterectomy.

may be hoped for by the performance of a vaginal hysterectomy, or, if impracticable by that outlet, removal of the growth through the abdominal walls, and a return of the pedicle to its previous location in the pelvic cavity.

It would be far from any thought of mine to offer personal views in this paper that might appear to be dictatorial, and I should justly suffer the charge of pedantry, I fear, were I to positively offer my humble judgment to the consideration of some of my listeners, whose experience in the treatment and removal of uterine fibroma has equaled if not exceeded my own; but yet I have some views to express upon this subject, which I trust will not be at variance with the observations of most of you upon this subject. If, however, my ideas may appear to be too radical in their expression, my hope is that they may be taken and accepted as from one in search of more light and knowledge in this complex branch of surgical progress.

As an introduction to the subject, a description of the nature and variety of these growths will, I believe, be proper, and will lead us to a more intelligent discussion of the methods of relief and cure. It is conceded on all sides that they are benign and non-malignant in their nature; that they grow so slowly, and so deliberately, as not to undermine the health of the patient unless she suffers from frequent hæmorrhages, or unless the growth, by its size, produces obstruction to proper performance of function by pressure upon the rectum and bladder, or upon the circulation in the blood-vessels adjacent to them; that they occur at all ages after puberty, but more frequently between the ages of thirty and forty years, and in the unmarried female rather than the married; that, very little if anything is known about the true pathogenesis of these growths; that, in regard to race, the negro is more liable to fibromata than the white, although no good reason has been advanced why this is the case; and that they originate in the middle

coat of the uterus, and in histological elements are the same as the tissues that produce them.

The various designations which have been given these growths, and which are accepted by gynæcologists and surgeons everywhere, are as follows: Fibroid, fibroma, fibrous myoma, fibro-myoma, and hysteroma. The terms fibroma and myoma are most frequently employed, I believe, and are preferred by myself in the discussion of these neoplasms. Fibroma grow usually in the body and fundus of the uterus (although in exceptional cases they are found located in the cervix), and for convenience of description and classification have been divided as follows:

When embedded and remaining within the middle coats of the uterus, *interstitial*; when growing outward from the surface of the organ, *sub-peritoneal*, and when there is a tendency toward the cavity, *sub-mucous*. As modifications of the above distinct varieties, there are also recognized two others, namely, fibroids of the broad ligament, and the cysto-myoma of the uterus. The first variety generally forms in the folds of the broad ligament. They do not become pedunculated, but extend outward, and by their weight soon drop deep into the pelvis, where they lie undiscovered until they become sufficiently large to rise above the pubes, into the abdominal cavity, unless, before this takes place, having displaced the pelvic viscera, they are outlined by the gynæcologist in his efforts at the restitution of the prolapsed organs.

The cysto-myomata are a class of tumors which have recently awakened great interest in the minds of investigators in this branch of science, especially on account of the difficulty of differential diagnosis from other abdominal tumors; principally, ovarian cysts. They sometimes reach a colossal size by cyst formation. They are not confined especially to the external or to the internal surfaces of the uterus, but are met with both beneath the mucous membrane, and beneath the peritoneal covering of the uterus.

Their origin is not quite clear; some authors interpret them as an œdema, others as a fatty degeneration, and still others as a species of general parenchymatous softening. These tumors may again be either single, multiple, or conglomerate. The solitary tumors consist of one body or mass; the multiple, of several masses situated apart, and at different portions of the uterus; while the conglomerate consist of a number of masses growing close together and surrounded by one capsule.

Fibromata occur only during the active functional life of the uterus. They become larger during pregnancy, diminish during the sub-involution of the organ, while after the menopause they disappear with the general atrophy of the uterus; although it is a well-known fact, that, in exceptional cases, in patients suffering with uterine fibroma menstruation is protracted for a period of ten years or more past the usual time for its cessation.

The course and symptoms of these principal varieties may be described as follows: The symptoms of myomata vary according to their origin and location. If a myoma be sub-peritoneal, if it is attached to the uterus in the shape of a small tumor, all symptoms may be absent; even during its growth it causes no more symptoms than the enlarging gravid uterus. Its symptoms, however, become more dangerous when the myoma, as more rarely happens, does not spring from the fundus, but from the cervix or, at least, from a low part of the uterus. Then, in its growth, it will be confined and incarcerated in the lesser pelvis, with pressure upon the bladder and rectum, producing in either, or both, partial, if not complete, interference with normal function, together with the unfortunate complication of adhesions taking place at points on either of these organs. Of the interstitial form, we may recognize the small encapsulated and the large diffuse myomata. The former, assuredly not rarely, cause dysmenorrhœa because they render the expansion of the uterus during menstruation difficult or impossi-

ble, and further the main effect of these small tumors is, that the upper part of the uterus, in which position they are generally situated, becomes heavier and hence the normal position more pronounced. Almost invariably we find an increased anteflexion and anteversion of the organ, and we are thus able to account for the strangury present in every anteflexion, which increases especially during the enlargement of the uterus. In the case of the large, soft, interstitial fibroids all symptoms may be absent. With these tumors the symptoms of swelling of the uterus during the period, and diminution during the interim, is observed with especial frequency. The great plethora of the tumor and consequently of the uterus leads to considerable menorrhagias. The hæmorrhages at times are so profuse that the patients are nearly ex-sanguinated. Hardly have they recuperated a little in the intermenstrual period, when the loss of blood recommences and continues violently for many days, or else the menstrual type disappears completely and the menorrhagia changes into permanent metrorrhagia. This is only variable in that, at times, dark, decomposed, almost tarry blood, and again bright and fresh blood, or else sanguineous, serous fluid is passed. Such patients appear very anæmic. The anæmia is distinguished from that of carcinoma by the absence of the waxy pallor of the complexion and the disappearance of the sub-cutaneous fat. Should the bleeding become at once profuse, there may be somnolence, amaurosis, and anæmic convulsion, as in death from hæmorrhage.

In the case of *sub-mucous* myomata all of those symptoms become prominent which are connected with pathological conditions in the mucous membrane. There is pre-eminently hæmorrhage. But while in the case of interstitial, soft, diffuse myomata the cavity of the uterus, enlarged but regular in form, allows the blood readily to escape, a sub-mucous fibroid may obstruct the cavity, or several tumors, pressing one against the other, may completely occlude the



efferent channel. The uterine cavity becomes dilated, the uterus expels its contents under paroxysms of pain, and frequent attacks of uterine colic occur.

*Diagnosis.*—The positive signs of fibroid tumors of the uterus are the increase in size, change of form and consistence of the uterus, and the displacement or distention of the canal, as related to its body; although it is apparent with what ease the gravid uterus sometimes may be taken, without close inspection, for an interstitial myoma, as happened in my own experience some months since. The clinical history of this case was one very unusual for a pregnant woman to recite. The long train of symptoms given were very unlike those we are familiar with in our everyday experience; no nausea, no feelings of life, slight if any change in the appearance of the areola about the nipples, together with an attack of metrorrhagia occurring at periods of several months during the previous year and a half. Besides, the appearances of pregnancy were further discouraged, to my mind, because a very capable and experienced physician of this city, previous to my examination, pronounced her non-pregnant; and what added further complexity to the matter of definite judgment, was the fact that the woman had been delivered thirteen years previously, and during the whole of that interim had not been pregnant until this time. I was disposed to diagnose the case one of tumor; but withheld my final preparation for an operation until an opportunity presented itself for a better and more careful examination at the patient's house. For this purpose, I invited Dr. Henry M. Lewis to visit the patient with me. She was prepared in her night-dress, and was placed upon a table preparatory to the examination. Dr. Lewis, preparatory to making an exploration, incidentally placed his hand upon the bared abdomen, when the reflex irritability caused by the cold hand produced a motion, which without further investigation dispelled any doubts as to the existence of pregnancy. Two weeks

afterwards I delivered the patient of a premature child of probably six months' development. It is a matter of surgical history that the abdominal cavity has been opened on many occasions only to find a gravid uterus in place of a fibroid growth, such a case happening to my own personal knowledge in this city, within the past five years, in the practice of a surgeon of unquestioned skill and long experience. The early symptoms of nausea, later on the the feelings of motion of the child, together with the sounds of the fœtal heart, are sufficient in all cases, where they are made out, to cause an explicit differentiation, although, in the case which I have recited, I failed at my office to hear the sounds of the fœtal heart for some reason, or feel the motions of the child which were so embarrassingly apparent at the time of my second examination.

While, after all, there is much in the history and development of these growths that makes the subject of one profound interest, yet to us it is a matter of greater import to decide as to the method, among those offered us, that will best relieve our patient of her continued sufferings and restore her to her wonted health, with the least danger to life. Besides we must discriminate as to those cases in which active or radical treatment should be advised or denied, or palliative methods substituted. While it might be accepted as a just criticism that too often we interfere by surgical means in our efforts to relieve the uterus of these complex growths, yet the world of progress would soon recede if efforts were not made in this, as well as other forms of vital surgery, to attain the goal of our desires by reducing the mortality after these operations, and combining therewith perfect success in our results. Operations that were considered unwarrantable, at no very late day, are now done with a precision and with results that prove, even to the most biased mind, that modern surgery has outstepped the most hopeful anticipations of our ancestors; but yet in our zeal careful discrimination should

always guide in the selection of the best means or methods to be employed.

There have been laid down by the profession of to-day plans of procedure which, before discussing in detail, I will simply enumerate: Ergot or ergotin, electrolysis, ecraseur, colpo-myomotomy, in which the operator attacks the tumor from below, laparo-myomotomy, by which the tumor is removed through the abdominal cavity; simple laparotomy, for the removal of the ovaries and Fallopian tubes, thereby cutting off the blood supply from the uterus in the hope of reducing the size of the growth and producing a sensation of hæmorrhage.

The action of ergot upon fibromata may accomplish a beneficial effect in two ways: First, by exciting uterine contractions it may produce expulsion of the tumor, if its relation to the uterine wall is such that it can be expelled; on this account ergot does its work more effectively in the sub-mucous variety of fibroma. Secondly, by causing contraction of the uterine walls, it may lessen the area of attachment of a sub-peritoneal fibroma, and arrest or retard its growth by diminishing its blood supply. Ergot is therefore simply an aid to the natural methods of disposing of these growths; namely, by expulsion, which in the sub-mucous, or intra-uterine varieties is often complete, the growth being wholly expelled from the uterus. In order to attain the best results of this remedy, it must be given in appreciable doses; sufficient to produce all the contractions of the uterus bearable by the patient, and, its use must be continued for a long time. In some cases it produces nausea and diarrhœa with loss of appetite. If so, it must be discontinued and an effort made in the use of ergotin subcutaneously. In some cases the size of the tumor is not diminished by its use, but it will frequently control the exhausting hæmorrhage, which certainly must be looked upon as a great advantage. When the patient can be guarded against great losses of blood, she may be able to live in

comparative comfort until the menopause has supervened. Of the ergot (fluid extract), I should advise doses of at least *one-half* teaspoonful three times a day, one hour before eating; of the ergotin, twenty minims in the abdominal walls, every other night on retiring. When expulsion, with or without the use of ergot, has taken place, the pedicle or attachment may readily be divided with the ecraseur, or the galvanic cautery wire. This method is simple in its performance and quickly done, generally with little or no hæmorrhage, although it was an experience of mine to have a profuse loss of blood come on some hours after an operation of this kind.

Regarding the use of electricity, the results in the hands of all practitioners, after patient and persistent trial, has given a varied experience as to the benefits derived in their cases. It has seldom cured, frequently benefited, and mostly been of little benefit. Knowing well the experience of Prof. Chas. Jewett, of Long Island College Hospital, to have been large in his application of electrolysis to these cases, I wrote him a letter from which I glean this question, "Has electricity ever cured a case of uterine fibromata in your hands, and what has been your experience in its use?" also, "Will you please give me the statistics of mortality in cases of abdominal hysterectomy at the Long Island Hospital or their percentage to this date?" I will give his letter in reply:

"MY DEAR DOCTOR:

"I have your note of this morning. In reply I beg to say that after a considerable experience in the treatment of uterine fibroids with electricity, I have seen no reason to believe they can be destroyed by galvanism without puncture. An œdematous fibroid may be condensed by the current and may remain smaller for a time, but absorption I believe is not possible. The galvanic current without puncture is valuable for the arrest and prevention of hæmorrhage, and to some extent for the relief of pain and pelvic tenesmus that frequently obtains in this class of cases, but no fur-

ther. The statistics of L. I. C. H. I could not give you, but have no doubt you could get them from Dr. Skene. Electricity, so far as I know, has not been used for that purpose in the hospital.

"Very truly yours,

"CHAS. JEWETT."

Taking his suggestion to communicate with Dr. Skene, I penned the doctor the following questions :

First : The percentage of mortality at the Long Island College Hospital after abdominal hysterectomy, and whether it has been greater by the supra or sub-peritoneal methods?

Second : Has electrolysis *ever cured* a case of fibroma of the uterus in your hands, and has it any value other than a hæmostatic in your judgment?

To which I received the following letter in reply :

"DEAR DR. JEFFERY :

"The mortality in my hospital practice after abdominal hysterectomy has been 20 percent. Supra-peritoneal method in all cases.

"I have completely cured three cases of uterine fibromata with electrolysis, and given perfect relief to ten, and partial relief to quite a number.

"Yours truly,

"ALEX. J. C. SKENE."

Fritsch, in speaking of the comparative effects of iodine and electrolysis, thus expresses himself: "The injections of iodine into the tumor are free from danger, as I have repeatedly convinced myself, but I have never seen any appreciable effect from them. The same may be said of electrolysis, with this difference,—it is not harmless." My own personal experience has been limited in the use of electricity in this form of cases, but my familiarity with several large fibroids in which it had been used has led me to doubt the value of its use with the hope of effectually destroying these growths. Still I am not unmindful of its possible advantage in cases where an operation for removal has been denied or failed in the efforts at extirpation.

We shall next discuss this subject in its surgical bearings, and touch upon several methods of interference. Some of you may possibly feel, and conscientiously too, that in preference to such extreme measures,—and I may say in place of them,—remedies may be found in our homœopathic text-books, that would attain the same results without hazarding the patient to the uncertain prospects of recovery. I might well wish that I could believe so, and take a view of the matter such as some of the members of our school, who feel, as to the homœopathic application of drugs, that surgery might give way entirely to the fuller domain of simple medicine. I cannot coincide with such a view, and do not yet believe that symptoms produced and exhibited in the sick from neoplasms, especially such as these under discussion, can ever be reached effectually by means other than strictly mechanical or surgical.

The question of importance, it seems to me, is not to select our method of preference and apply it without discrimination, but to apply our best judgment and forethought to those cases which we believe require the knife, and those which may be approached and relieved by other means. I believe that in small tumors, modern authors agree that to remove them by the vagina is the better plan, unless the removal of the ovaries and Fallopian tubes are substituted as the point of procedure.

If a tumor is proven to be of the sub-mucous variety, and can be surrounded at its pedicle by the ecraseur, and there divided, this would seem to be in my judgment the preferable way of dealing with it. This method looks very simple and effective on paper, but let those of you who have never tried endeavor to properly get the loop around the pedicle of a tumor that partially disturbs the uterus, especially a short pedicle, and you will at once become aware that this plan, while seductive in the description of the method, is a very troublesome and often impossible task to accomplish. If on the other hand we are dealing with an

interstitial or sub-peritoneal fibromata, no plan, in my judgment, supersedes the removal of the ovaries and Fallopian tubes, provided, however, the growth is no larger, and the abdomen is distended no further than would be apparent in a gravid uterus at the fourth month, as at this time the ovaries can generally be reached and manipulated (a condition frequently impossible where the uterus has risen high in the abdomen). In such a case the ovaries and tubes are found behind the growth and generally adherent to it. I believe, however, that in any case all surgeons familiar with the performance of this operation, hold in reserve the removal of these organs, if they can in any way be gotten at, provided the growth is irremovable owing to adhesions or other adverse conditions. The effects of extirpation of the ovaries and Fallopian tubes is to control the exhausting hæmorrhage, besides causing a shrinkage of the growth, which obtains in nearly every case. It should be understood, however, that this method of treatment is still under consideration in many minds, although I believe that I am justly warranted in saying that all who have practiced this method have obtained as good results as by any other plan, excepting favorable terminations after laparo-hysterectomy. Wildow states that in seventy-six cases, the menopause occurred immediately in sixty-one. In four cases the effect upon the hæmorrhage was but temporary. In sixty-three cases the fibromata diminished. In three there was a primary diminution and subsequent increment of the tumor. Besides this, Schroeder reports that after this method the cure has lasted but a short time, and that the tumor had grown after castration, although he reports some successful cases.

In my own experience I have removed the ovaries and Fallopian tubes on nine different occasions and in three of these for uterine fibromata. In all cases the growths were small, but seemed unmanageable after a reasonable trial of other methods. In two of the cases the tumors have shrunk

to less than one-half of the previous size, without a return of hæmorrhage at any time since. One of these cases, however, presents a point of interest, and I will recite it. This patient recovered satisfactorily to all appearance from the results of the operation, and had passed out from under my professional care. I saw her frequently for several months afterwards and she gave me reports at all times of a very encouraging nature. On a date nearly six months after the operation, I learned from a friend of the patient that Mrs. — was flooding profusely, every few days, and was feeling badly and exhausted from the constant loss of blood to which she was exposed. I very naturally expressed great surprise at this information, which from my own experience and that of others was an unlooked for occurrence. Three or four days after this time I was sent for during the night to find my patient suffering from great abdominal pain together with a considerable rise in her temperature. To condense further details of the case I will say that she died in a couple of days afterwards of an undoubted case of general peritonitis. Why she had the recurrence of hæmorrhage or why the peritonitis supervened at so late a day, I was very much to my regret unable to learn, as the performance of an autopsy was denied me. Another circumstance to be considered in relation to this or other methods requiring abdominal sections, is the likelihood, no matter what care may be exercised, in placing the sutures in the abdominal walls, of a ventral hernia adding as much inconvenience to the patient in after years as a tumor could ever give, with this difference, that the tumor if left undisturbed may be improved by the menopause, while nothing, excepting the danger of a second operation, offers the patient any escape from the inconvenience and burden of a truss or abdominal bandage for the remainder of her natural life.

There is a division in my mind of this subject which makes this a good place to fix it. Namely, barring all of the uncertainties—which are not many—of a favorable result, I



would name the removal of the ovaries and Fallopian tubes as the proper method of treatment in all cases where we are dealing with a small tumor. In other words, if the growth has not risen above the pubes, extirpation of the ovaries, if other methods have failed. If above the pubes, perform laparo-hysterectomy or removal of the uterus and tumor together in interstitial or sub-peritoneal growths. In the sub-mucous variety simply divide the pedicle and remove the growth through the dilated cervical canal.

Fritsch and Schroeder both agree that they would see castration resorted to only as a forced substitute, when the removal of the myomata is impossible, as frequently occurs from the products of adhesive inflammation holding the tumor fast in its bed in the abdominal cavity.

In entering upon a discussion of the question of the total removal of these growths by abdominal section, we are touching upon a subject which has excited a varied expression of opinions throughout the medical world. Considering the risks to the life of the patient, where palliative means may be employed, that may make her comfortable until the menopause has been reached, when the changes in the uterus, characteristic of that period, may prove to be the best remedy, we have a question worthy of honest thought in the mind and heart of every conscientious surgeon. To be sure antiseptic methods, the thorough and careful application of means to destroy septic germs, has greatly lessened mortality statistics, but yet the most exacting care and preparation cannot always avert the dangers of shock, or secondary hæmorrhage, and sepsis, and its accompanying peritonitis, are perils that no methods of skill in the most chosen hands have been able to avert. Yet desperate conditions require desperate remedies. In tumors that have become a burden by their weight, or prostrating by the freedom of their hæmorrhage, and have defied the employment of palliative means, it becomes a question of such importance to the patient that she is driven to the unhappy

alternative of choosing a life worse to her than death could ever be, or accept the goodly chance of relief that total extirpation offers her—to such a case any operation, however extreme, seems to me to be a justifiable procedure—and should be advised. But many of the cases which consult us are not of this desperate variety; many patients suffer with comparatively slight hæmorrhage, others have little or no pelvic tenesmus, and it is to this class of cases that careful and mature judgment as to our best plan of procedure should conscientiously guide our choice.

At the beginning of this article you will remember that I spoke of the diversity of judgment among surgeons that made their guidance for action very indefinite in the treatment of these cases. I have tried to discuss the different varieties of these growths, and the most approved methods of treatment as tersely and circumspectly as possible, and when we pause to consider the diversity of symptoms, the fair physical condition of one and the broken health of another, it shows us at once that we are not dealing with anything short of a most complex and conflicting subject. It is not to be wondered at, then, that all who have had a practical experience in this matter, and the treatment of these tumors, should sometimes, on the most vital points, wander away from each other so often by diverse and contrary paths of reasoning. I should like in closing this paper to lay down what to my mind should be the axiom to guide us all in the treatment of these growths, viz.: To try the simple means always at first; if necessary afterwards, the radical. Then if our efforts are not crowned by successful results,—after careful consideration by the patient of the dangers and risks to her life she is assuming,—take upon ourselves the removal of the growth through an abdominal incision, which after all contributes the largest mortality of any method or plan of treatment. How much better off would our civilization be, and how much less rapidly the records of mortality would accumulate, if precision of

method and unanimity of action could be given us by some unseen hand in the vital treatment of this and other forms of formidable disease? We have not yet the goal of perfection in our medical and surgical ambitions, and must yet, at least for a while, humble ourselves to the truthful adage of Sir Isaac Newton, who compares us with little children playing with shells upon the shore, while the great ocean of truth lies undiscovered before us.

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## HYGIENE OF THE EYES OF CHILDREN.

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BY

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*(Continued from Page 346.)*

HYGIENE OF THE EYE DURING THE EDUCATIONAL PERIOD.—Having made a brief digression in the preceding JOURNAL to discuss errors of refraction, we will return to a consideration of those factors which can influence the eyes, for good or for bad, during that period of childhood in which these organs are most employed for near work, the educational period. And as we, in the United States, have little to do with tutors and governesses, but instead send our children to the public schools, it is obvious that the strictest supervision of these institutions is necessary, in order that the eyes may be surrounded and protected by the best possible conditions for near work.

First of all, it is necessary that the school-room may be supplied by proper light, *natural not artificial*. The light should never be excessive, nor on the other hand should it be insufficient. Especially should the use of light that shines directly into the eyes be prohibited. It is necessary that the light be so distributed to all parts of the school-

room that pupils distant from the windows will not be deprived of the quantity of illumination requisite to their work. A French commission appointed in 1881 has studied this question at great length, and has recommended that the pupils most distant from the window ought to see the sky in a vertical extent of at least thirty centimètres, computed from the upper part of the window. This commission did not express a preference between bilateral or unilateral illumination. E. Trélat, Galezowski, Javal, and the majority of eminent ophthalmologists, are, however, in accord in demanding the unilateral illumination from the left side of the pupil, in all cases where the conditions are such that this light may be furnished in sufficient quantity, even to the pupils most distant from the window. These things not being equal, bilateral illumination then is necessary.

The preference for the unilateral illumination from the left proceeds from the necessity of avoiding the shadow of the right hand upon the paper in writing.

In deciding upon the question as to the sufficiency of light, we may say that the illumination of the scholar's work is sufficient when one can read fine type without difficulty at the distance of twelve inches from the eyes in the most poorly lighted parts of the school-room.

We may also say, in general, that the illuminating area occupied by the school-room windows ought to more than equal one-fourth the superficial area of the floor. The windows ought also to occupy a vertical extent equaling from one-half to two-thirds the height of the room. More than this, the top of the window should be placed very near the ceiling to allow the lower casing at a height which will protect the eyes from those direct rays of light which windows brought down near the floor would transmit. In this manner will be procured the best illumination for near work.

READING—WRITING.—Next to proper illumination, it is necessary to provide books of a type that does not produce

a strain on the accommodative power. The French commission of 1881 arrived at the following conclusions on this point: Books should be printed on white paper, or paper of a slightly yellowish tint; the lines should have a length of 7 to 8 centimètres at the maximum, to abridge the movements of the eyes as much as possible; the letters should be well spaced, and should not exceed 7 to the centimètre, and every book which, illuminated by a candle at one metre distant, ceases to be legible to good vision at 80 centimètres should be discarded; an atlas, likewise, of which the maps, when held vertical and illuminated by a candle at one metre, are not legible to a normal eye at a distance of 40 centimètres should not find place in the school-room.\*

With regard to writing, the child should be taught a large, round, legible hand, to always avoid bad attitudes at the desk, especially myopic children, guarding against bending over the work and bringing the head too near the desk. The school-room furniture, however, will have much to say to vicious attitudes in reading or writing. We cannot, of course, expect Utopia in the school-room; we cannot, under present conditions, fit every scholar with furniture suited to his case only, but there are certain relationships that ought to be fulfilled. These involve certain principles that have been touched upon by so many authors that we will only rapidly review them. The great thing to avoid is reading or writing at less than 33 centimètres. To this end it is necessary to adapt the furniture to the size of the child. The desk should incline at an angle of 15 degrees; it should be of a height convenient to support the forearms during writing, yet allowing the child to lean against the back of the chair. The distance which separates the chair from the desk should be nearly one-eighth of the whole body; that between the seat and the floor should be two-sevenths of

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\* This last should be especially insisted on. The strain on the accommodation, in trying to decipher the small names so mixed up on the modern atlas, is more than any eye should be subjected to.

the whole body.\* Seated in this manner the child has the least possible temptation to assume attitudes in too close proximity to near work.

Errors of refraction have already been considered, and it remains but to say that all the hygienic measures demanded for the preservation of the vision of children during private life need to be redoubled when those that are victims of myopia, hyperopia, or astigmatism become exposed to the irritative conditions which may affect the eyes during school life.

So far the question of artificial light has been avoided, because the less we call on children for near work with artificial illumination, the less will we endanger their eyes during a period in which the tissues of these organs are very susceptible to strain. The establishment of night-schools, however, for those who are unable to attend a day-school leads at once to the discussion of artificial light.

No artificial light can ever replace the light of day; because all kinds of artificial illumination contain a greater proportion of yellow rays than of green, blue, or violet; because they have greater heating properties; because they are unsteady; and because they vitiate the atmosphere.

The incandescent electric light (such as the Edison or Swan system) if properly placed and surrounded by proper protection has the least disadvantages. It contains less yellow rays than any other artificial light; it is less vacillating than the common gas jet, and, by surrounding the illuminating point with a ground glass globe, a very soft white light may be produced.

Gas, for lighting a large room for night-school, has the inconvenience of great heating power and of consuming large quantities of oxygen. According to the experiments of Dumas, one gas-jet, burning 158 litres of gas in one hour, absorbs 234 litres of oxygen (one litre=61.027 cubic inches) in order to produce, by the combustion of its hydrogen and

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\* Galezowski, "Hygiène de la Vue."

carbon, water and carbonic acid gas (128 litres); and during this hour it elevates the temperature from zero to 100 degrees centigrade. To completely eliminate possible harm, then, from the number of gas-jets needed in a school-room, will require very careful adjustment of the ventilating apparatus.

But, no matter what the advantages or disadvantages of any artificial light may be, it cannot be other than a source of danger to the children's eyes unless properly placed. The light must not be too far above the child's head. It should be so surrounded by a shade as to protect the eyes from the direct rays and at the same time throw all the light upon the work. If gas or oil be used there should be an arrangement by which a current of air carries all the heat away from the eyes. In a word, the eyes must be protected from too great or too little light, from heat, and from all *direct* rays of artificial light.

In conclusion it is hoped that the attention of those *not specialists* will be drawn to the lamentable ignorance and prejudices of the general public on all ocular questions, and that the result of this work will be that each family physician will consider it a special duty to watch over the hygiene of the eyes of the little ones intrusted to his charge.

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## CLINICAL CASES OF ALBUMINURIA.\*

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BY

J. N. ECKEL, M.D.,  
SAN FRANCISCO, CAL.

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CASE I.—Mrs. H——, age thirty-eight, of good habits, requested me to see her October 20, 1889. Patient had fever; temp. 103° F.; complained of sore throat, difficulty

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\* Read before the Gynæcological Bureau of American Institute.

of swallowing, tonsils swollen and highly inflamed, pain in the back, and an aching all over the body. Patient had attended the burial of a friend; while in the cemetery a heavy rain commenced, and she was thoroughly drenched. On the way home she felt chilly. Prescribed the usual remedies for fever (acon. and bella.), for sore throat. Eight days later, I noticed œdema of the eyelids and ankles. Patient said she had a disposition to pass urine often, but in small quantities. Urine examined; albumen, blood, corpuscles, a few hyaline casts, and epithelium cells. Terebinth. 3x every three hours continued for a few days, until albumen decreased, followed by Ars. 3x. Exclusively milk diet. In four weeks from first visit, the patient was well.

CASE II.—Master C——, twelve years old, had scarlatina when six years old. Mother tells me that her son complains of being tired, loss of appetite, at times very irritable; at night he had to get up to pass urine in small quantities at times, and other times he would pass more. He complained of a tired feeling across the loins. I discovered a perceptible œdema of the eyelids, patient looked pale, temp. normal, urine dark yellow at times, and at other times clearer, according to the mother's statement. Milk diet ordered. As the patient had an aversion to pure milk, I gave skimmed milk, about four tablespoonful every two hours, increasing the quantity hourly. Terebinth. 6x four times daily. Patient was well in three weeks.

CASE III.—Miss L. R——, thirteen years old, was taken suddenly ill with chills, followed by fever, on November 6, 1889. While running home from school was caught in the rain. Temp. 104° F., pulse 120, restless and delirious during the night, in the morning the sensorium clear. Patient complains of pain in the lumbar region, urinates often.

Nov. 7—Temp. 103°. Nov. 8—Temp. 102½°. Nov. 9—Temp. 101½°. Nov. 10—Temp. 99½°. Nov. 11—Temp. normal.

Urine was examined the second day. Albumen and a



few hyaline casts. Disease continued four weeks, and it was surprising how rapidly the albumen disappeared. Apis 6x every two hours for four days, followed by terebinth. 6x every three hours, a few hot-air baths the third week; diet exclusively milk. I forgot; the patient had the first day acon. 2x. During convalescence ferrum ars. three times daily. As the patient complained of being weak, Bordeaux wine with her meals.

In all cases of albuminuria, I follow up a persistent use of milk or skimmed milk, sometimes buttermilk. In chronic cases often kumyss, now and then a soft-boiled egg, from which I saw no bad effects. Professor Senator of Berlin asserts that the use of eggs in albuminuria is injurious, whilst, on the other hand, Professor Oertel allows eggs and the patient does not get any worse from it. Tea and coffee, all highly seasoned foods are not allowed, nor salt meats.

*General Remarks.*—Balsac said that almost the whole of human genius consists in "observing well." Whether I have given proof of being a good observer, others will have to judge. The cases described and several others appear in my practice in the last twenty months, and give evidence that albuminuria is very common in our city; not less than sixty-five deaths from diseases of the kidneys occurred within three months. Morbus Brightii furnished the greatest number. The treatment was simple enough. The diet, which consisted almost entirely of milk, was strictly carried out by the patient; without that no satisfactory result could have been expected. The examination of urine might have been made with more care, particularly the microscopic investigation. A busy practitioner is not always master of his own time. The amount of albumen in some cases was small, in others large, one-third, one-half, or one per cent., yet sufficient persistently present for days, even weeks. The symptoms were but few, yet strikingly so to point to a reliable remedy. It is not always necessary

to have many symptoms; nevertheless the trouble in the kidneys could not be mistaken.

A few years ago I was called in consultation by a *confrère* to examine a patient. All she complained of was a constant nausea, yet albumen was found in large quantity; on boiling the urine, a solid clot of albumen was the result. Last fall an old man of seventy-five years consulted me about his "bladder trouble," a constant urging to make water, and the various remedies, as terebinth., uranum nit., ars., dig., had no effect. The disease progressed; the patient complained for a few days of vertigo, which was relieved by kalmia. He went about and attended to his business until the anasarca was well on the way. In this case the amount of albumen was not large.

I have to confess, in the congestive albuminuria, albumen is often the only symptom. Naturally, we find besides albumen, hyaline casts and blood; patients complain of pain in the lumbar region, which disappears often from itself; at other times the pain is more persistent; then again, the patient experiences pain on pressure, either on one or both sides of the kidneys, or it extends from the latter downward into the bladder. Fever is present in some cases, in others it is wanting; accelerated pulse, thirst, coated tongue, a tired feeling, want of appetite, nausea, aversion to food, or vomiting, and constipation. The presence of fever would indicate more than hyperæmia. The kidneys are more likely in a state of inflammation. Notwithstanding, the patient will recover in the course of three or four weeks and even sooner. Albumen, also blood, hyaline cylinders or epithelium products, even pus are found. All disagreeable feelings in the region of the kidneys disappeared, the abnormal specific weight of the urine changes to the normal, from a small quantity of urine to a larger one. If the fever increases, we notice, evening and night, exacerbations; the patient has also chills, even rigors, ending in perspiration, a pseudo intermittent character of fever, eventually more a

typhoid type; if the urine is dark brown and very fetid, then we suspect sloughing of the kidneys and the typhoid condition has reached its maximum. Death follows by exhaustion. Acute inflammation of the kidneys goes over to a chronic form, which is generally called morbus Brightii or diffuse nephritis; some authors call it nephritis parenchymatosa, others nephritis granulosa, others nephritis albuminosa. The latter nomenclature is simple, yet the most appropriate, as in many diseases albumen is found. Clinically the prime character in diseases of the kidneys is, after all, the condition of the urine, its quantity, quality, its specific weight, and morbid elements. The definition of morbus Brightii, yet imperfect, implies a variety of pathological conditions and symptoms not alone of the kidneys, but other vital organs; not alone a pain in the kidneys and bladder, condition of urine, habits of the sick one, blood, dropsy, conditions of the digestive and respiratory organs, circulation of blood, nervous system, etc.

The various forms of morbus Brightii are as follows: A long-continued, diffused inflammation of the kidneys, where the most essential symptoms showed themselves later on and produce a fatal termination in a few days. Another form, whereby with a somewhat uræmic condition, with typhoid symptoms, death occurs from eight to fourteen days,—or we have an acute form with moderate dropsy; the general appearance of the patient is good, and in from two to three weeks the patient is convalescent; or we have a very acute form of a sthenic inflammatory character, hot skin, full pulse, occasionally severe symptoms of suffocation, intense pain in the lumbar region, with active hæmorrhage of the kidneys; or the leucophlegmatic asthenic form, where the patient is, from the inception of the disease, very weak, the œdema more of a doughy nature, pulse small, and the digestion shows an early disturbance; then we can formulate a caæhetic form with similar symptoms, just mentioned, super-induced by previous diseases, as, for instance, long con-

tinued suppuration, long continued intermittent<sup>1</sup> fever, progressive tuberculosis of the lungs, a long continued use of alcohol, or lead poison, chronic syphilis, mercurial cachexia, cirrhosis of the liver.

Some writers consider a peculiar form of morbus Brightii that follows cholera, where the hydrops is absent ; its progress is very rapid, where either the patient recovers rapidly or perishes soon of uræmia. Another peculiar form is the one produced by scarlatina or small-pox, typhoid fever, etc., we might call acute infectious (or desquamative) nephritis ; another, the toxic form, caused by over-doses of chlorate of potassa or bichromate of potash, etc. ; another form which is produced by valvular trouble ; another form is the puerperal, which to this very day is not satisfactorily understood. Schroeder cites Ingleslew, who collected a hundred and six cases of eclampsia, which showed no albumen in the urine, and at the post mortem the kidneys were found normal. Prof. Leyden cites similar cases. The constant presence of albumen in the urine is a pathological product ; besides albumen, hyaline casts or lymphoid cells, blood corpuscles or hæmatin crystals of Hiller, etc. Albumen is found in many cases of diphtheria in the beginning of the disease ; however, I never observed but one case of dropsy. In scarlatina, we look for it during the latter part of second week. An active hæmorrhage may be often the advance-guard of albumen ; in fact, I have seen even œdema of the eyelids, hands, and ankles, yet on examination of the urine no albumen was found the first few days ; then again, it may be found several successive days. English authorities claim that " taking cold " during desquamation is the cause of albuminuria, whilst the German pathologists assert that cold has nothing to do with it. I have seen children with dropsy, who had the best possible care, were kept in a temperature from 68° to 70° during their sickness, yet two out of three children in one family had dropsy, only in one case

could I ascribe it to exposure. There may be in some family an inherited disposition, according to Dr. Delafield.

Steiner makes the following remarks in his compendium on diseases of children: "Congestion or hyperæmia and catarrh of the tubuli of the kidneys are constant companions of scarlatina. We have an exfoliation of the epidermis and we have a similar process going on within the lining of these little tubules." Even the tubal nephritis, as Dickinson says, may be fatal, whilst the textures of the kidneys are healthy. Prof. Bartels positively asserts that micrococci, others speak of diplococci, play a conspicuous part, and which are found in endless numbers in the kidneys during the stage of desquamation. This scientific assertion has certainly no clinical advantage. A few hyaline casts do not make the case a serious one. It is more the retention of the urine, it is the anuria that gives us the greatest anxiety, which produces often a fatal ending in twenty-four hours, especially when the patient passes only a few tablespoonfuls of urine. The œdema does not always follow as a rule; instead of œdema of the eyelids and ankles, showing signs of the presence of albumen, the scrotum and labia are œdematous; afterwards general dropsy appears with the well-marked pale condition of the mucous membranes. Also the urine undergoes many changes in color, at times apparently clear, then dark red, brown or blackish, indicating the presence of blood. We often have active hæmorrhages. In meager eruption in scarlatina variegata, I have met with dropsical symptoms. Children had good appetites; urine was examined daily—no albumen was found, now and then traces of it. There should be no doubt in all infectious dropsy; the vaso-motor nerves have something to do with it; then again, in some cases, even fever is absent.

What is the cause of uræmia? This question has been discussed by prominent medical writers of all countries. Hardly two authors agree. Whilst some say uræmic con-

vulsions are caused by a ferment in the blood, others, as Prof. J. Lewis Smith of New York and Prof. Thomas of Leipzig, say the great toxæmia of the blood and the high temperature; others ascribe it entirely to the morbid condition of the kidneys. Uræmia is owing to a number of morbid conditions; changes in the blood, of the capillary blood-vessels and blood-current. These three conditions must bring about a fatal issue. Allowing our reasoning powers to go a little further, the greater the toxæmia the greater the pyrexia, the more the muscular contraction of the heart suffers, the more the nerve ganglion of the heart becomes depressed, the weaker its action, the more likely a complete stasis is the consequence. We have a higher venous pressure and a lesser capillary one. In uræmia we have, if not a deficient secretion, certainly a faulty excretion, and ingredients of the urine which should be carried off become absorbed. Yet clinical experience tells us that the retention of urine, causing a complete anuria, does not always produce at once convulsions; for instance, Biermer cites a case of anuria lasting ten days, with moderate dropsical trouble, and during these days no convulsions appeared. The kidneys performed their functions during the short period of three and one-half days; nevertheless the patient died. Deininger had a case of anuria lasting eight days, and the patient got well. Another one is cited by Miller, the anuria lasting thirteen days, and the patient recovered. Pisano had a case, a boy five years old, anuria lasting ten days, œdema was absent; and Henoch mentions one of seven days anuria, and during this time the patient did not complain. Anuria, clinically considered, is a dangerous phenomenon, and the patient is not safe as long as it exists. Death is surer than life. The uræmic convulsions appear suddenly, often without a material deficiency of the urine; in other cases we have prodromal symptoms, such as headache, nervous agitation, sleeplessness, or we have coma. The headache is so severe that patients act like maniacs,

and have a desire to get out of bed or run away. Little ones have grinding of teeth, opisthotonus, rapid respiration, foaming at the mouth, epileptiform convulsions, and, in a complete comatose condition, life ends. The quickest death is from œdema of the lungs. Years ago I saw a case of uræmic convulsions, which a physician of the old school had abandoned. Anuria of two days' duration, the bed-clothes were saturated with blood. Patient had no œdema. Curara 2x relieved, and the patient made a speedy recovery. Besides the indicated remedy for dropsy in exceptional cases, as adjuvants when the skin is hot and dry, I use hot-air baths for several days in succession, and it is surprising how rapidly the œdema subsides; it is only used with patients whose sensorium is free; otherwise, I use the warm-water pack. Prof. Bohn of Königsberg remarked: "Since I make use of cold water during the febrile stage of scarlatina, I have not met with dropsy." To this sensible remark, I say, "Amen," and confidently add, "Since I used warm baths during the stage of desquamation, I have not met with a single case of dropsy in the last twenty-five years."

Priessnitz, although considered a humbug forty years ago, has found admirers amongst the best old-school practitioners. Hahnemann, "the German dreamer," they still abuse, although many of his remedies are used on the sly, without a proper and honest acknowledgment from which source they came.

Hahnemann lives more than ever. "Magna est veritas et prevalebit."

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## ✿ EDITOR'S TABLE. ✿

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—There have been of late so many inquiries from our associates for an article on the relation between diseases of the eye and diseases of the female genital organs that we venture to devote a little time to the discussion of a late work in

this direction by Dr. Salo Cohn (Uterus und Auge. "Eine Darstellung der Functionen und Krankheiten des Weiblichen Geschlechtsapparates in ihrem pathogenen Einfluss auf das Sehorgan)."

Dr. Cohn studies first those ocular troubles which may appear during the course of menstruation, either normal or pathological; he then passes successively in review the ocular affections of pregnancy, of accouchement, of the puerperal state, and of lactation. We will follow this arrangement.

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—Concurrently with the menses there is sometimes observed on the cornea an herpetic eruption, analogous to that which we sometimes notice about the mouth. As another order of phenomena there sometimes appears, through a mechanism of compensation, venous congestion of the fundus of the eye, papillitis, and even retinal hæmorrhages.

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—In anomalies of menstruation the disturbance of the equilibrium of the diverse functions of the organism is of course greater than in normal menstruation, and ocular diseases are more common. In a general manner, there is to be observed in dysmenorrhœa a narrowing of the visual field (this symptom is often but slightly marked); ordinarily this symptom is produced when the loss of blood is diminished in quantity.

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—With amenorrhœa, Mooren has seen a coincident interstitial keratitis and atrophy of the choroid, and these lesions were benefited as much by emmenagogues as by special medication. Congestive accidents or even hæmorrhages of the fundus of the eye and into the conjunctiva are not rare in amenorrhœa. These troubles, however, are not only seen during confirmed amenorrhœa but may also show themselves at the beginning of menstrual life, at puberty, when there is difficulty in establishing first menstruation. In these cases, even optic neuritis, proceeding to atrophy, has been cited.

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—To return to dysmenorrhœa again, taking now the confirmed form, we may have the same order of ocular disturbances as in



amenorrhœa, but the morbid condition which predominates is a *sub-acute irido-choroiditis*, with glaucomatous symptoms. When the dysmenorrhœa depends upon a particular general state, there is found in the ocular accidents the factor of diathesis. It is thus that scrofula produces a phlyctenular keratitis, conjoined to dysmenorrhœa; if the general state is one of anæmia or chlorosis, we may have, added to painful menstruation, a muscular asthenopia, or a chromhydrosis, that singular affection characterized by an exudation of bluish color into the skin of the eyelids.

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—In dysmenorrhœa caused by an actual genital lesion, such as uterine displacement for example, one meets more particularly an interesting class of variable ocular troubles; these are fugitive disturbances, susceptible to arising, passing, and returning again and again, succeeding one another with more or less regularity. These troubles consist either of amblyopias, or of hyperæsthesias, or anæsthesias of the retina, or, again, of a variety of asthenopia.

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—The same ocular disturbances (following an analogous pathogenetic process) are found among subjects addicted to masturbation, and, in general, among those that present an exaggerated excitation of the genital system. Mooren cites a case of amblyopia following as a consequence of a simple introduction of a speculum.

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—When hysteria can be traced as a direct factor of ocular disturbances there will be especially observed the characteristic limitation of the visual field and dyschromatopsia. More rarely in parallel cases there are produced muscular troubles characterized by paralyses, diplopia, and diminution or spasm of accommodation.

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—A sudden suppression of menstruation is often followed by a repercussion (so to speak) on the side of the eyes. There have been noted, under this head, hæmorrhages of the ocular fundus, and even of the anterior chamber, neuro-retinitis, and retro-bulbar neuritis. Teillais has cited an example of sanguine-

ous transudation of the vitreous without apparent lesion of the retina. All these accidents may give rise to grave irremediable lesions such as detachment of the retina and especially atrophy of the optic nerve.

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—In pregnancy we often see the various ocular phenomena of muscular and accommodative asthenopia, which arises from the general asthenia proper to this particular physiological state. But the most frequent of the ocular affections linked to a gravid uterus is, as all know well, *retinitis albuminurica*. In this case the entire retina, but especially the layer of rods, is involved in an infiltration that is rapidly transformed into fatty elements. Of all the hypotheses that have arisen to account for the retinal changes in this disease, the most probable is that of Graefe and Nagel, who directly attribute the albuminuric retinitis to the special alterations of the blood. The ophthalmoscope reveals a mass of bright disseminated spots in the region of the macula. It is necessary not to confound albuminuric retinitis with uræmic amblyopia. This last disease comes on suddenly in eight to twelve hours, and is accompanied by other phenomena of uræmia. Besides, uræmic amblyopia furnishes no ophthalmoscopic symptoms.

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—Among the reflex nervous phenomena which are met with during pregnancy there is one trouble that deserves special mention, that is hemeralopia or nocturnal blindness. This symptom generally occurs about fifteen days before accouchement and usually persists during the puerperal state for a nearly equal period of time. The intimate cause of this nocturnal blindness, when occurring during pregnancy, is in much doubt. Treitel attributes it to a simple default of adaptation, while Parinaud and Kuschbert attribute it to a defect in the production of the retinal purple. However, the macula lutea, which contains no trace of the retinal purple, is attacked by the hemeralopia as well as the rest of the retina.

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—During the puerperal state there may occur certain conditions that may be properly called ocular accidents. In the first

place may be noted embolism of the retinal arteries or of the ciliary arteries. If the condition is one of simple embolism there will be present the characteristic œdema of that territory of the retina which is involved, with a corresponding scotoma. If the embolism is of septic character there is danger of infection, with a resulting panophthalmitis. To this ocular condition, due to infection, conveyed by the blood from the uterus to the eye, we give the name metastatic panophthalmitis. The eye thus attacked is not always doomed to total loss of vision; the infection may be of only slight degree and give rise to the metastatic irido-choroiditis.

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—In terminating there are a few words to be said on those ocular disturbances which accompany or follow metrorrhagias. Aside from the ordinary symptoms of asthenopia, which follow all asthenic states in uterine disorders, there has been noted, more especially, a retinal anæmia which gives a particular ophthalmoscopic appearance. The fundus of the eye becomes entirely pale, to such a degree that it is difficult to distinguish the arteries from the veins. But the hydræmia resulting from excessive metrorrhagia may give origin to an entirely opposite condition, and cause the development of neuro-retinitis, or even a hæmorrhagic neuro-retinitis with hæmorrhages into the vitreous. The fluidity of the blood appears to be the principal cause of these sanguineous effusions.

## ● GOLDEN GRAINS. ●

—Belladonna is especially useful for enlargement and induration of the axillary glands occurring in females at the climaxis.

—According to Dr. Olliver, the nocturnal grinding of the teeth among children may be : (1) A simpletic of sleep, comparable to snoring, and in this case has an unlimited duration, and indicates a particular state of the nervous system which depends upon inheritance. It appears more common among young girls predestined

to hysteria ; (2) In a great number of cases the grinding of the teeth is due to a febrile affection, acute or subacute. It is observed in the prodromal stage of meningitis, and in certain cutaneous eruptions.

—Pulsatilla is almost always the remedy in the cystic symptoms that accompany pregnancy. It is not at all a first-class remedy in true cystitis, but is adapted to the transient bladder symptoms that frequently annoy the pregnant woman.

—M. J. Blechmann (*Paris Médical*) advises the treatment of cracked or fissured nipples by means of goldbeater's skin. Over the nipple affected by erosions or fissures, after wetting with simple clean water, there is applied a round piece of goldbeater's skin, of about 10 centimetres in diameter. The center of the skin is first pierced by a number of fine holes with a needle. The skin takes the form of the nipple and adheres like a second epidermis. The external surface of the goldbeater's skin may now be moistened and the infant applied to the breast. The nipple is thus isolated from the child's mouth, and has a chance to heal without suffering the constant irritation from contact with the lips of the infant. After each nursing a new piece of skin should be applied.

—Cuprum is a good remedy for crampy after-pains in women who have borne many children.

—Helonias is useful for suppression of the menses when the kidneys are congested. It seems as though the monthly congestion, instead of venting itself, as it should, through the uterine vessels, has extended to the kidneys, giving rise to albuminuria. The urine is scanty and turbid.

—Syphilides of the vagina have, from the point of view of contagion, an especial gravity, due, on the one hand, to the absence of analogous lesions (either on the vulva or on the skin elsewhere), and, on the other hand, to their location in the folds of the vaginal mucous membrane. M. Balzer (*Concours Médical*) insists on the difficulties of diagnosis that he has met in several cases where the ulcerations, seated either in the cul-de-sac or in middle portion of the vagina, have only been discovered by repeated, minute examinations, when their existence had been proven be-

yond doubt by the contagion of several males. In one case in particular, in a prostitute, a large mucous *plaque* had developed in the cul-de-sac and coincided with a uterine deviation which hid it. The ulcer was discoverable only on lifting up the cervix.

—There is another drug besides Helonias that has some marked reflex bladder symptoms in uterine troubles, and that is *Senecio aureus*. Farrington describes it as especially suitable to nervous, excitable women who suffer much from sleeplessness, traceable to uterine irritation, as from prolapse or flexion of the uterus. With regard to the sympathetic bladder symptoms, there is much distress at the neck of the bladder causing pain, burning and dysuria. After the onset of the menstrual flow these cystic symptoms become modified or cease, thus showing the reflex relation existing between the menstrual irregularities and the bladder.

—In twenty autopsies made at the New York Infant Asylum, of cases of infantile tuberculosis, it was noted that in seventeen cases there was a fairly even distinction of tubercle on the surface and in the substance of the lung. There was tuberculosis of the lung in every case but one; of the lung only, in two. In twelve cases there were cavities; and in five of the remaining eight, cheesy nodules, some breaking down. The organs were involved in the following order of frequency: Lungs, nineteen; spleen, fifteen; brain, eleven; kidney, three; peritoneum, one; and pericardium, one. Bronchial glands enlarged in every case, same with mesenteric glands, and in many cases broken down. A positive tubercular history was obtained in three cases only.

—In measles, where the rash does not come out properly, when the child is hot, tosses about, crying out in a frightened manner as soon as it falls asleep, with convulsive movements and a bright red face, you have a case to which stramonium is adapted.

—Dr. E. Frank, at a recent meeting of the German Medical Society at Prague, related a case of chronic urticaria complicated with bilateral oöphoritis and salpingitis. After radical operation for the relief of the latter affections she remained free from her

former skin trouble. Dr. Frank considers this to be sufficient proof of the nervous or reflex character of the urticaria in this particular case. The connection of cause and effect was quite manifest. Synchronous beginning of both troubles, increase of the symptoms and eruption at the menstrual period, etc., and complete cure with removal of the diseased organs, are certainly sufficient proofs.

—*Cina* has been pointed out as a remedy for whooping-cough, when during the cough the child stiffens out and its muscles become rigid. With this there is, in addition, as distinguishing features, a clucking sound down the œsophagus as the child goes out of the paroxysm. Grinding of the teeth at night is also marked.

—Concerning the hygiene of cholera infantum, Dr. Claiborne has a few practical words. We must be careful to keep the child cool. During the "heated term," as it is called, the air within the house is often colder than that out-of-doors; select the coolest and airiest room of the house; not under a slate or tin roof, but on the first or second floor of the dwelling, and keep the child indoors as long as the air outside is hotter than that inside. Select a room with as little furniture and as few occupants as possible, clean floors, and bare of carpeting, and keep the bed in the center of this room. Use a hair or air mattress, and keep the child out of the hot arms or lap of the nurse. Remember, when he is lying on the lap of the nurse, he is lying on a bed of the temperature of 99°, and possibly not always a sweet or cleanly one. Let his dress consist of one light cotton garment loose and short; keep a thermometer in the room, and as long as the mercury remains in the neighborhood of 95° do not change his clothing. When the mercury falls below 80°, whether by night or by day be ready with a little slip of a more substantial sort, and a thin flannel bandage for the bowels; and put them on at the slightest indication of coolness of the surface or extremities. When the temperature out-of-doors falls, and becomes more pleasant than that of the house, take the child out if a proper place can be secured free from wind and dust and unsanitary surroundings.

—It cannot be doubted, says Professor Fournier, that hereditary syphilis, by reason of the state of relative impoverishment in which it places the organism, constitutes a decided predisposition to various maladies. It is incontestable, for example, that these infants are especially subject to affections of the nervous system. A great number die of convulsions and meningitis. Even if syphilis be not a direct cause of rickets, it is certain that it predisposes to it in a powerful manner, and that it represents one of its factors. Furthermore, the frequency of scrofulo-tuberculous affections in infants the offspring of syphilitic parentage has long been noted, and the possible transformation of syphilis into scrofula has even been discussed. This theory, however, after the discovery of the bacillus of Koch, cannot be longer sustained ; but it is not less certain, for all that, that the syphilitic soil is eminently fitted and lends itself willingly to the culture of the bacillus. It is, in short, undeniable that hereditary syphilis pays a large tribute to the diverse manifestations of scrofulo-tuberculosis, and notably to affections of bones,—such, for example, as Pott's disease and hip-joint disease.

—Dr. Rakusa, of Odessa, Russia, has performed supra-vaginal amputation of the uterus in twelve cases. In nine of these cases the operation was resorted to for the removal of uterine fibromyomata ; in a tenth case it was performed for hæmatometra, complicated by hæmatosalpinx and hæmatocolpos ; in the eleventh the uterus was removed in the course of a double ovariotomy on account of the extensive adhesions of the cyst with the womb ; in the last case an osteo-sarcoma of the pelvis necessitated Porro's Cæsarean section. In seven cases the operation was made after Kleberg's extra-peritoneal method, all patients making good recovery. In the remaining five cases, an intra-peritoneal operation was performed, with three recoveries and two deaths from peritonitis. Dr. Rakusa makes the following conclusions : 1. The extra-peritoneal method gives far better results than the intra-peritoneal. 2. Even under strictest antiseptic precautions the intra-peritoneal amputation is always associated with the danger of a secondary infection. 3. The operation is justifiable only in cases of pedunculated fibroids, and in those where the stump is very short.

—In hysterical tympanitus Dr. P. Jousset (*L'Art Med.*, May, 1890), recommends *Taraxacum leontodum*. He has prescribed it several times with success; particularly in a grave case, which in a preceding attack had undergone intestinal puncture, this remedy was administered in half-drop dose of the tincture every quarter hour. After the second dose amelioration began, and was soon followed by the evacuation of an immense quantity of gas with rapid cure of the tympanitus. The indications are entirely empirical.

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## ● GYNECIC ETCHINGS. ●

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—Porak has studied the laws of the passage of chloroform through the placenta (*Rev. d'Obstet. et Gyn.*, March, 1890). He finds that even when the mother absorbs great quantities of chloroform, very little passes through the placenta. The foetus, not being able to eliminate this agent by the lungs, casts it off by the urine. The chloroform accumulates in the brain, existing only in very small doses in the blood, not to be recognized chemically. The existence of these small doses of chloroform in the foetal organism has no serious influence upon the health of the new-born. The author thinks, then, that the danger to the child does not furnish a contra-indication to the use of chloroform in obstetrics.

—Dr. J. Leeser (*Allgemeine Hom. Zeit.*, Dec., 1890), cites a case of a woman who had a tumor of the left breast, pronounced by two allopathic physicians to be cancerous. Examination revealed a swelling nodular, hard, the size of a walnut, in the upper part of the left mammary gland, and also a hard swollen gland the size of a bean in the left axilla. On account of the presence of painful points in the tumor, chelidonium, 30 C., was prescribed in Aug., 1888. With the continued use of chelidonium the axillary gland had disappeared by Jan., 1889, and the tumor had become softer and diminished one-half in size, and by May 15, under the further use of chelidonium, the tumor of the breast had entirely disappeared.



—Physicians are often perplexed as to their proper course in attending a woman upon whom a criminal abortion has been attempted or accomplished. Are such cases to be reported, and if so, to whom and when? If the patient dies, the case should be reported to the coroner, but until the death of the patient, neither coroner nor medical examiners have any official concern in such matters, although it not unfrequently happens that the cases are reported upon death. Medical men are not informers or detectives, and are not called upon to make known their suspicions, however strong, but if a physician actually knows that a crime has been committed, he is not safe in concealing the knowledge. In any case, the prudent man will fortify himself by a consultant.

—Dr. Saulmann of Brussels has had excellent success in the treatment of vaginismus with the continued current. The negative pole, in the shape of a large plate of metal covered with absorbent cotton, is placed on the abdomen [Dr. Martin's abdominal electrode would be better]; the positive pole in the form of a bulb is placed alternately on the perineum and in the vaginal entrance.

—Abet (Thèse de Paris, 1889, *L'Art Médical*) claims that the maximum diuretic effects of *chimaphila umbellata* are attained by the administration of 12 to 15 grm. of the hydro-alcoholic extract made from the powdered leaves. The diuresis increases during the first twenty-four hours and attains its maximum in three or four days. It is especially useful in the asystolic period of heart disease from its power of reducing oedema by diuresis. It appears to have no direct action on the heart. The alcoholic extract is not toxic nor cumulative in its effects.

—Dr. Södermark (*British Med. Jour.*) describes the occurrence of prolapse of the urethral mucous membrane in women, and expresses surprise that it should be thought such a rare accident, having met with three cases within three years. In one case, the patient was fifty-eight years old, and was also subject to prolapsus uteri, cystocele and rectocele. A fleshy mass, the size of a walnut, partly sloughing, occupied the site of the urinary meatus. The entire outgrowth was removed with the galvano-cautery,

whilst the vagina was narrowed anteriorly and posteriorly by a plastic operation. The result was satisfactory. The second patient had reached the age of seventy. For years a swelling the size of a plum, consisting of the mucous membrane of the urethra, had projected from the meatus. In a third case, that of a child nine years old, the prolapse also consisted of urethral mucosa. It was removed with scissors, and the edges of the raw surface left behind were united by sutures. We see thus that prolapse of the urethral mucous membrane is not unknown even in children.

—During a number of years past, writes a correspondent (*La Gazette Médicale*), I have used the spirits of turpentine in puerperal hæmorrhages with the best of results. When the ordinary methods, friction over the uterus, irritation of the uterus with the fingers, hypodermic injections of ergotine, have failed, I have always succeeded in bringing about uterine contraction, and instant cessation of the hæmorrhage, by saturating a bit of linen with turpentine and introducing it into the uterus. In two cases, when the patient was almost pulseless, it appeared to act as a stimulant.

—Dr. Chaput, of Paris, comes to the support of those who admit that portions of retained placenta may remain alive and develop into placental polypi. Dr. Chaput reports two cases (*Bulletins de la Soc. Anat. de Paris*) where the placenta lived after the arrest of normal pregnancy. In the first case abortion occurred at the second month and the placenta was retained for two months. In the second case the foetus died at the third month, and was retained, with its placenta, for two months longer. The child and its appendages were removed with fatal results to the mother. Both patients were multiparæ, and over thirty-five years of age. The tissues of the placenta, on microscopical examination, presented neither atrophy nor continuance of normal development. A singular change had taken place. The villi had decreased greatly in number and lost their vessels; on the other hand, those which remained were from double to ten times their natural size, and contained numerous cells, some very large, without distinct nuclei. The great lesson taught is, of course, that a retained placenta ought always to be removed, even though we

may be much in doubt as to whether it will perish by gradual atrophy or by more or less sudden decomposition.

—Freund (*Berl. klin. Wochenschr.* 1890, No. 11) recommends ichthyol very highly in inflammatory diseases of the female genital system. He has used it with success in chronic parametritis, in chronic and subacute perimetritis, in chronic metritis and salpingitis, in erosions of the cervix, etc. He prescribes ichthyol, both internally and externally simultaneously. Internally is given a tablet of 0 gramme. 1 of ichthyol three times a day; later this dose is doubled. For local application Dr. Freund employs:

Sulpho-ichthyolate of ammonium..... 5 grammes.  
Glycerine..... 100 “

M. Sig. Apply in the vagina a tampon soaked in the solution.

In some cases he orders a rectal suppository of:

Ichthyol..... 0 gr. 05.—0 gr. 2.  
Cacao butter..... q. s.

Erosions of the cervix are treated with applications of pure sulpho-ichthyolate of ammonium. The action of the ichthyol is manifested first in the rapid resorption of exudations, and finally in its soothing and antiphlogistic effect. In one case an effusion into Douglas's cul-de-sac was absorbed in sixteen days, tumefaction and induration rapidly diminishing from the first application.

—There are a few remedies which we have had occasion to compare with silicea in the nervous headaches of women, where the pain ascends from the occiput into the head. These are *menyanthes*, *paris quadrifolium*, and *strontiana carb.* The pain of silicea ascends from the nape of the neck to the vertex and thence into the supraorbital region. It is worse from any noise, motion, or concussion, and better from wrapping the head up warmly. Under *menyanthes* the headache also comes up from the nape of the neck and extends over the head. There is a bursting pain, as if the membranes of the brain were tense and were pushing the skull open. This pain is distinguished from that of silicea by the fact that it is relieved by pressure rather than warmth. *Paris quad.* also has a headache which arises from the nape of the neck and produces a feeling as though the head was immensely large. *Strontiana carb.* approaches the nearest to silicea of all

these headache remedies. It produces a headache coming up from the nape of the neck and spreading thence over the head ; and this pain is relieved by wrapping the head up warmly, just exactly like the silicea headache, but under strontium we have the distinguishing feature, that this neuralgic pain begins lightly and increases gradually to its greatest intensity and then gradually declines.

—M. Grammatikati (*Jour. Accouch. i jensk. bol.*, No. 12, 1889) has studied the modifications of the endometrium that takes place consecutive to cancer of the cervix. He has had an opportunity to observe the uterine mucosa in four cases in which he performed extirpation for cancer of the cervix. In one case there was glandular endometritis ; in two cases, interstitial endometritis ; and in the fourth case there were found epitheloid modifications of the cells of the mucous membrane, and an infiltration which Grammatikati considered a carcinomatous degeneration of the connective tissue cells. The author believes this case to be a new proof of the fact "that cancer develops sometimes without any relation to a pre-existing epithelium, and that it is often difficult to trace a limit between sarcoma and cancer."

—*Staphisagria* is often a valuable remedy in the ovarian irritation of nervous, excitable women. Particularly is it valuable in the hypochondriacal moods of this class of women when an ovarian irritation arises during the absence of the husband, from allowing the mind to dwell on sexual subjects.

—Glavecke (*Arch. für Gyn.*) describes his researches into the changes that occur in the female genitalia after ovariectomy or castration as follows : The vagina is the site of varying changes after castration. In general, diffuse hyperæmia of the mucous membrane follows, sometimes attaining a degree closely resembling that found in beginning pregnancy ; frequently, copious secretion is combined with this state. In three out of nineteen cases the author failed to note this hyperæmic state ; he thinks that such may be explained by the fact that the vagina in some cases at once undergoes atrophy without the intervention of the hyperæmic stage. In the atrophic stage, the vagina becomes considerably shorter and narrower, generally, however, allowing

the passage of two fingers. The atrophy takes place much more rapidly than in the physiological climacteric. The atrophy did not in general implicate the labia majora and minora and the mons veneris.

The cervix uteri undergoes a slow shrinkage in texture and volume; it becomes more slender and tender, a little shorter. If ectropion existed, it rapidly disappears, erosions and ulcerations at the lips heal rapidly, cervical catarrh rapidly diminishes and disappears without further local treatment. The uterus after castration undergoes slow but steady atrophy, and to a greater degree than the other genitalia; it matters not whether it be enlarged by tumors or chronic inflammation, or is of normal size. The process begins promptly after castration.

—English authorities are yet unsettled as to the justifiability of the extirpation of the ovaries solely for the purpose of effecting a change of life for the cure of diseases. Many hold that the operation is only justifiable for the removal of positive disease apparent in the ovaries. Lawson Tait denies that "change of life" has anything to do with the accomplishments of the cure of diseases for which we operate. Dr. Robert Battey, in his address to the South Carolina Medical Association, among the American surgeons believes that change of life is the great thing we seek. The fact that he does not always get immediate results from the operation does not dismay him at all. For when he analyzes the results of Mr. Tait and others he finds that they get no more prompt results than he does. With them one, two, or three years elapse before their desired results occur—time long enough for the setting up of this cyclical process that Dr. Battey contends goes on in the female organs, and which is the essential element of the cure. Hence he holds his ground as to his theory and practice so as to accomplish a "change of life."

—In order to learn if puberty can be admitted as a cause of insanity, and if (the insanity of puberty being admitted) this form of alienation takes a special course, M. Mairet has gathered all the observations of insanity following in the changes of the period of puberty that he has been able to find, and has studied them first in the point of view of their etiology. From this study

it has resulted that these observations can be divided into two groups : in the first, puberty has had no influence with regard to causation ; in the second, it has really played the rôle of an efficient cause. There exists, then, an insanity of puberty.

This point established, the cases were further studied comparatively in regard to the symptomatology of these two groups of facts. From this it was found that in cases when the cause clearly depended upon puberty, the disease had a special clinical physiognomy, which it had not in the other cases. Insanity of puberty deserves then, a clinical description. But contrary to the opinion of Kahlbaum, M. Mairet believes that this physiognomy is not always the same. Sometimes the insanity of puberty shows itself as an *arrest of development*, with or without concomitant delirious symptoms ; sometimes it produces only a perversion of intelligence, which is manifested by *maniacal delirium* (choreic, impulsive, hysterical), or by *lypemaniacal stupor*.

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### BOOK REVIEWS.

THE MEDICAL ANNUAL AND PRACTITIONERS' INDEX, 1890. E. B. Treat & Company, New York.

If there has been anything new in medicine or surgery during the past year it can certainly be found in this yearly index of medical literature. The scope of the work covers all departments, and we therefore have room for only a brief notice of the parts pertaining to obstetrics and gynecology. Under the heading Obstetrics, we note succinct reviews of such new topics as Dr. Hank's advocacy of the use of electricity in ectopic pregnancy, Prof. Simpson's address on the preventive treatment of intra-uterine death, and new drugs in obstetrical practice (pilocarpine, antipyrin, and viburnum prunifolium). In the gynecological sections of the work, the ground gone over during the year is well covered, especially with regard to diseases of the uterine appendages. Of course, referring to uterine therapeutics we can agree with very few of the ideas advanced as to the efficiency of the latest remedies, but we do find some tolerably good homœopathic prescriptions, such as *cimicifuga* in dysmenorrhœa, and *pulsatilla* in delayed first menstruation.

**THE HOMŒOPATHIC TREATMENT OF ALCOHOLISM.** By DR. GAL-LAVARDIN. Translated from the French by IRENÆUS D. FOULON, A.M., M.D., LL.B. Hahnemann Publishing House. Philadelphia, 1890.

This work appears as the first monograph ever written, from a homœopathic standpoint, upon alcoholism. While we cannot agree with the author's views in every point, and cannot refrain from questioning some of his statements, yet we feel that he has, by long years of experience, earned the right to an impartial hearing of his methods. The work contains a valuable repertory of the therapeutics of alcoholism.

**THE CONCORDANCE REPERTORY OF THE MORE CHARACTERISTIC SYMPTOMS OF THE MATERIA MEDICA, Vol. I.** By WILLIAM D. GENTRY, M.D. A. L. Chatterton & Co. New York, 1890.

We have already accorded a brief notice to this book, but a pressure of literary work at that time prevented more than a mere acknowledgment of its appearance. To day we are prepared to more carefully review this Repertory, particularly with regard to the interest it holds for the gynæcologist. Vol. I. contains a very important section for the specialist in diseases of women, namely, "MIND AND DISPOSITION."

Every careful prescriber bears well in memory that the rubrics of mind and disposition diligently worked out have helped him to cure many an obstinate case of female trouble; and, we have no doubt, he also recalls many a weary hour's search for obscurely worded symptoms. With this repertory it would have been a task of but a moment to ascertain to what remedies such and such a symptom belonged. For our own part, we remember a few months ago a search through our repertories for remedies to compare with *pulsatilla* in "weeping mood." Turning to "weeping" in Gentry's work we find nearly two pages of symptoms relating to weeping and to weeping mood. We now appreciate the great value of this repertory in gynæcology, when we realize how full a comparison might have been made in only a few minutes.

It would be a great pleasure to go through each of the remaining sections of Vol. I., HEAD AND SCALP, EYES, EARS, NOSE, and FACE, and point out the features that are particularly interesting

to the gynæcologist, but, to the careful student of *materia medica*, its value in correlating the symptoms of remedies, in prescribing for ovarian or uterine complaints, is already manifest.

**OVARITE-SALPINGITE-ADHÉRENCES.** Par le DR. JUST LUCAS-CHAMPIONNIÈRE. A. Coccoz, Libraire-Editeur. Paris, 1889.

The author, who is rapidly becoming one of the foremost French surgeons, has presented us with the results of 75 laparotomies in his own practice. Within a pamphlet of 60 pages, he has recorded a number of original conclusions, as to symptoms, pathogeny, pathology, and operative procedures, in ovaritis, salpingitis, and pelvic adhesions. Several pages are devoted to the pathological anatomy of salpingitis; a very welcome addition to the literature of the subject, as his descriptions are derived entirely from his own original observations. The chief feature of the work is the section devoted to adhesions. Championnière has performed laparotomy, for the purpose of freeing the pelvic organs from adhesions, in ten cases without a death. The cases range from pelvic adhesions resulting from retro-uterine hæmatocele to those that proceed from an attack of pelvic peritonitis. In some of these cases where he has operated solely on the indication of abdominal and vesical pains, that pointed to adhesions involving the bladder and intestines, M. Championnière's results have been very satisfactory, the woman experiencing entire relief from pelvic pain and discomfort after the adhesions had been separated by laparotomy. The author terminates by expressing his views thus: "I believe, in fact, that we have not paid sufficient attention to the destruction of adhesions in the cure of abdominal pains. When it is remembered that the epiploic adhesions in a hernia suffice to determine such acute pains that life is a misery, we will note more clearly the disorder wrought in the functions of the pelvis, or among all organs subject to distention and to congestion. Thus, the detachment of adhesions has caused simultaneously the disappearance of the menstrual pains, of the pains due to the dragging on the peritoneum, those caused by fixation of the intestine, vesical disturbances, and all the misery dependent upon an habitual congestion of the pelvic contents."



THE CONCORDANCE REPERTORY OF THE MORE CHARACTERISTIC SYMPTOMS OF THE MATERIA MEDICA. Vol. II. By WILLIAM D. GENTRY, M.D. A. L. Chatterton & Co. New York, 1890.

This volume, containing sections on the symptoms pertaining to the MOUTH, THROAT, STOMACH, and HYPOCHONDRIA, is particularly interesting to the obstetrician. Though in our possession now only a few weeks, it has proven of great assistance by the help it has afforded us in prescribing for the vagaries of the pregnant state. Under STOMACH the few pages on *desires* and *aversions* will, we predict, be of great value in selecting a remedy for the vomiting of pregnancy. The pages devoted to a collection of the symptoms relating to "*nausea*" and to "*vomiting*" do certainly constitute the most complete repertory of those conditions that has ever been published.

When first we took up this work, in its initial volume then, we confess it appeared largely theoretical, and particularly so as there was such a mass of symptoms which were unverified; but with everyday use its practical value is becoming more and more manifest, and we can easily overlook what seems, here an omission, and there an unnecessarily complicated symptom. And, in fact, these apparent faults of verbiage have, in several instances, when referring to its pages, proven of inestimable value by affording a clue to remedies not mentioned in other repertories.

FAMILIAR FORMS OF NERVOUS DISEASE. By M. ALLEN STARR, M.D., Ph.D. William Wood & Company, New York, 1890.

Dr. Starr presents us with a neurotic *olla podrida* from which, however, in spite of its lack of classical arrangement, we are able to pick out a number of valuable clinical studies. The portion of the work devoted to the cerebral functions and cerebral localization contains a succinct review of the literature of the subject that is complete to date. "On the localization of spinal cord diseases" the author presents considerable originality in his teachings of this subject, and gives some new schematic diagrams that are truly of great value for diagnostic purposes. "The paralyzes of infancy" are of particular interest to us. The chapter on Erb's paralysis of the arm (that lately described by Duchenne as "*paralysie obstétricale infantile du membre supérieur*") contains a very practical study of the disease as observed by Dr.

Starr in the clinic room, and we regard it as the best effort of the work. Lastly, on the subject of "*reflex pains*," the author gives a very original diagram of the topography of pains that appear in various parts of the body in the course of uterine and ovarian affections.

HANDBOOK OF MATERIA MEDICA AND HOMŒOPATHIC THERAPEUTICS. By TIMOTHY F. ALLEN, A.M., M.D., LL.D. F. E. Boericke, Hahnemann Publishing House. Philadelphia, 1889.

Although this volume has now been in our possession some time, we still find it difficult to deliver an opinion on its merits. A number of criticisms have already appeared on the unwieldy character of the book, but as defects of this kind are rather foreign to the nature of what is intended here, we prefer to deal with the author's share of the work and let the publishers take care of their own department. First, we want to say, that whatever Dr. T. F. Allen does is always done well and in a classical manner, and that we know of no other man who could, *single-handed*, produce a work of this character within so short limits of time. But, and right here we deal with a very severe criticism, the literature of the materia medica of to-day, with its clinical verifications, has multiplied so fast that we consider no one man (no matter how varied his attainments) equal to the task of collecting and analyzing the vast array of provings and clinical symptoms and verifications that now exists.

So far we have not had time to go over the general character of Dr. Allen's work, but, with regard to that which especially interests us, namely the gynæcological sections, a careful reading shows decided deficiencies. As a matter of reference it never will take the place, in gynæcological work, of Minton's "*Uterine Therapeutics*." If we were allowed a prediction, we would say that the materia medica of the future will consist of several volumes, of convenient size for ready reference, edited by a man of impartial, logical, and analytical mind, with the assistance of a corps of specialists, each one of eminence in a particular branch of medicine. Until this acme of materia medica making is attained, however, we shall depend on the "HANDBOOK" for general reference.

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VOL. XII.

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BENIGN GROWTHS OF THE UTERUS.\*

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MYOMA, FIBROMA-MYOMA, FIBROID TUMORS, LEIOMYOMA, FIBRO-CYSTIC  
TUMORS, FIBROUS POLYPI, FUNGOID ENDOMETRITIS, GLANDULAR  
POLYPI, CELLULAR POLYPI. (*The last three are varieties of Adenoma*)

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BY

G. R. SOUTHWICK, M.D.,  
BOSTON, MASS.

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These growths are considered in one chapter because their subjective symptoms are similar, differing only in degree, according to the size and situation of the tumor, and the same general principles of treatment apply to all.

The myoma, or fibro-myoma, also known as a fibroid tumor, may be single or multiple, the size of a pea, or large enough to fully distend the abdominal cavity, and usually has a distinct capsule, especially if it be of long duration. It is most common near the fundus uteri, on the posterior wall, and is seldom found in the cervix. The surface is smooth, as a rule, rarely a little irregular. The stony hard-

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\* From advance proofs of Southwick's "Practical Gynæcology."

ness of a circumscribed mass within or in connection with the uterus is characteristic of a uterine fibroid. Microscopically, it consists of hypertrophied connective and muscular tissue, and the degree of hardness depends largely on the density of the muscular elements. Though generally very hard, myomas are sometimes found which have a moderate amount of elasticity, and are therefore called soft or œdematous myomas (Lawson Tait). In myxo-myoma of Virchow the muscular fibres are not as compact, are separated by a jelly-like substance, or cellular bodies which grow rapidly by proliferation of the cellular elements, and the tumor is composed almost entirely of muscular elements. The soft myomas grow more rapidly than the hard, occur in younger women (Virchow), and may become myxosarcomatous. They are often observed to vary in size, being larger just before the menstrual periods. Dr. Arthur Johnstone believes that these soft myomas have their origin in the glandular structure, or, as he terms it, the adenoid tissue of the endometrium.

Endometritis is generally induced by the presence of a myoma tumor, especially if it be of the sub-mucous variety. In examining numerous preparations, Dr. Wyder found glandular endometritis accompanying interstitial and subserous myomas. This glandular endometritis was more marked in proportion to the thickness of the muscular wall between the tumor and the uterine cavity. The thinner the wall, as in sub-mucous myomas, the greater the growth of connective tissue (interstitial endometritis). The glandular endometritis shows no predisposition to malignant degeneration of the mucous membrane, and in the pure form Dr. Wyder believes it does not cause bleeding. Bleeding is in consequence of the development of connective tissue and blood-vessels (endometritis fungosa); or if one portion grows very much faster than another, it may compress the veins, forming large sinuses, cause the blood to stagnate or back up in them, and thus produce hæmorrhage.

Apart from the inflammatory disorders of the pelvic tissues, and anomalies of menstruation, this affection is one of the more common, if not the most frequent, of the diseases peculiar to women. Myomas are also found in various parts of the body, less often in the male than female. They are almost unknown before or at puberty, but from this time gradually increase in frequency, and in the majority of cases develop between thirty and forty years of age. Their growth is very slow, usually ceasing after the climacteric, and life is endangered only in consequence of mechanical pressure or profuse menorrhagia. When small, and situated beneath the peritoneal investment of the uterus, there are seldom any symptoms, and the patient may never be aware of their presence, unless they are discovered immediately after labor, when the uterus is so easily felt through the relaxed abdominal walls.

The negro race is peculiarly liable to their development, much more so than the white. It seems to be true, also, that of the large pelvic tumors, myomas predominate in the African, and ovarian in the white races.

The relation of the etiology of myomas to single, fruitful, and sterile women has been carefully studied, and nearly all observers find that they are much more common in married than single women. Gusserow collected the records of nine hundred and fifty-nine women affected with these growths. Six hundred and seventy-two were married, and two hundred and eighty-seven unmarried. Of the married ones four hundred and sixty-four had borne children, and the remainder were sterile. He believed, from the recorded experience of physicians, that the sterility was a result rather than a cause of the development of the tumor. Both Schroeder and Winckel agree with him in this opinion.

In five hundred and fifty-five women having uterine myomas, Winckel found one hundred and forty (24.2 per cent.) were childless and single; four hundred and fifteen

were married (75.8 per cent.), and of these one hundred and thirty-four (24.3 per cent.) were sterile. According to the population of Saxony, the proportion of middle-aged married women to single women was as 9 to 7.3, and the prevalence of myomas among the unmarried to that among the married was 3 to 9; in other words, tumors of this nature occur nearly twice as often among the married as in the unmarried.

Leopold found in four hundred cases that 81 per cent. of the tumors were in married women, 19 per cent. in the unmarried, and the proportion was a little larger for sterile married women than for the unmarried.

Gusserow and Schroeder believe that sexual gratification rather favors the development of uterine myomas.

While these opinions concerning the etiology of uterine myomas have obtained general acceptance, there are some physicians who differ from them. In a very carefully written essay, based on great experience and the personal study of over two hundred cases, Dr. Emmet thinks those women who have not had children, i. e. the unmarried and sterile classed together, are more liable to myomas than those who have borne children. According to him, the fruitful are more liable than either the unmarried or sterile considered separately, while the last two classes are nearly equal in liability before thirty years of age. He believes their development is held in check by marriage, even though conception does not take place; also, that "between the ages of thirty and forty the unmarried woman is fully twice as subject to large myomous tumors as the sterile or fruitful," and that sterile women are more subject to small myomas than either unmarried or fruitful women; he is also of the opinion that sexual gratification diminishes the liability to myomas.

The complications and symptoms are those arising from pressure of the tumor on the neighboring structures, and increased determination of blood to the uterus. They vary



omewhat, according to the situation of the tumors, which for convenience of description are divided into,—

Sub-peritoneal myomas, when situated beneath the peritoneal covering of the uterus (25 per cent.).

Interstitial myomas, when situated in the parenchyma of the uterus (65 per cent.).

Sub-mucous myomas, when situated beneath the endometrium, and projecting into the uterine cavity (10 per cent.).

These forms mix with one another in great variety, though one type usually predominates.

If a sub-mucous myoma projects far enough to have a distinct pedicle, it is then termed a fibroid polypus. It is probable that many myomas begin as interstitial tumors near the endometrium or peritoneal surfaces. As their size increases, they tend to grow in the direction of the least resistance, and, with the help of muscular contraction of the uterine parenchyma, become eventually sub-serous or sub-mucous myomas.

*The Symptoms* are most pronounced, and constantly produced, by sub-mucous myomas and fibrous polypi; less frequently by interstitial; and are often few or entirely absent in the sub-peritoneal variety. Profuse menorrhagia or metrorrhagia is one of the most constant symptoms; and in the interval between the flowing there is a watery or leucorrhœal discharge of bloody serum from the uterus. This is a loss of lymphatic fluid which may weaken the patient nearly as much as hæmorrhage. The flowing first appears as an increase of the monthly flow, and gradually becomes excessive with later periods, instead of a sudden and profuse hæmorrhage, as in carcinoma. There is also more or less weight and bearing down in the pelvis, pelvic pain, irritability of rectum and bladder, and pain along the course of the crural nerves, all of which result from pressure. Pelvic pain and pain in the limbs, like sciatica, is especially common with myomas, developing posteriorly

on the uterus and low down in the pelvis. Dysmenorrhœa is sometimes present, and is sometimes one of the earliest manifestations, together with pain in the intermenstrual period. Though these symptoms may be marked, the diagnosis of uterine myomas cannot be made without—

*The Physical Examination.*—Large myomas, extending into the abdominal cavity above the brim of the pelvis, are readily diagnosed in the great majority of cases by abdominal palpation. They are more often sub-peritoneal than sub-mucous, uniformly hard, and may be situated at the center or on one side of the abdomen. The surface is generally irregular, from the presence of one or more smaller myomas, all of which form a single mass, held together by a framework of connective tissue; or, less frequently, the surface is smooth when a single tumor is present. Like all myomas, they develop slowly.

Sometimes the myoma may project far enough from the uterus to have a short, thick pedicle; but the uterus will always move with the tumor, as shown by the introduction of the sound within the uterine cavity, and motion given to the tumor will be communicated to the sound.

While the presence of a large myoma can almost always be ascertained by the means just indicated, it is well to follow the method of examination given below for a small myoma, which is sometimes difficult to detect with absolute certainty.

The best time to make an examination is very soon after the monthly has ceased, though this is by no means necessary or advisable if the flowing is almost continuous. The tissues are then more relaxed, the cervical canal open, and the cervix soft, allowing a certain amount of dilatation with the finger as the uterus is crowded down upon it by the external hand. The tumor, therefore, can be felt better at this time.

In all cases it is a good rule to have the patient in a position in which she can be examined to the best advantage.

Although a fair idea of her condition may be obtained while she lies on her back on a firm mattress or sofa, it is much better to place her on a table or gynæcological chair. All constricting bands about the waist, and corsets, must be removed, and the thighs flexed on the abdomen to relax the muscles as much as possible. In all doubtful cases, ether anæsthesia will be of great assistance in making a thorough examination. A hot (110°) mercurial douche (1-4000) before and after the latter is also advisable.

It is hardly necessary to state that the bimanual method of examining must be an invariable rule, and the cultivation of a gentle touch without prying and prodding about in the pelvis is very desirable.

The cervix quite commonly is found displaced. If the tumor be large, extending above the pelvic brim, the cervix is often drawn up, and sometimes out of reach, though the uterine cavity may not have much more than a normal depth. When the tumor is in the anterior or posterior wall of the uterus, that organ is displaced in the corresponding direction, particularly if it be of the sub-peritoneal variety. This and the relation of the growth to the uterus are readily ascertained by careful bimanual palpation. In exceptional cases, when the myoma is sub-mucous, less often if it lies in the posterior uterine wall, the cervix is low down in the pelvis. The stony hardness of the tumor, which is seldom sensitive to pressure, its slow development, associated as a rule with menorrhagia in a woman about forty years old, are very characteristic symptoms of a uterine fibroid.

It is not always as easy to distinguish the class of myomas to which it belongs. The sub-peritoneal may be felt like a hard lump attached to the uterus, sometimes having a sort of ring or constriction at that place; while the intramural (interstitial) feels more like a hard bunch bulging out from that organ, with a perfectly smooth, sloping surface, and no constriction around the base of the tumor, and

an increased depth of the uterine cavity. A rectal examination will often be of great service when the tumor is in the posterior part of the pelvic cavity. If the myoma be sub-mucous, the fundus is more symmetrically enlarged than in either the preceding varieties. Sometimes the tumor is readily felt presenting at the external os; or by crowding the finger firmly up in the cervical canal, and pressing down on the uterus externally, it is distinguished near the internal os.

It is always desirable to ascertain, approximately at least, the extent of the attachment of sub-mucous myoma to the uterus. The first step in making this estimate is to find the depth of the uterine cavity, which is generally the distance from the external os to the upper border of the base of the tumor. A whalebone probe, the best instrument for this purpose, is passed up to the fundus uteri, taking care that it will go no farther by introducing it once or twice in a little different direction, as the point is liable to catch in some fold of tissue; the forefinger is then placed on the probe, close to the cervix, and the instrument is withdrawn. Making a little allowance for the curve of the probe over the tumor, the instrument is laid on a piece of paper, on which are marked the points corresponding to the tip of the probe and the external os. It is then reintroduced along the opposite surface till it reaches the tumor, the finger placed on the probe next to the cervix, and again withdrawn. It is marked along the same line on the paper, and the distance between the two points corresponding to the tip of the probe gives a fair idea of the thickness of the base of the tumor; while the freedom with which the instrument will move laterally over the growth shows the breadth of its attachment.

When the base of the tumor extends low down in the uterus, it often encroaches on the upper part of the cervical canal, making it difficult to introduce any instrument, and giving rise to the impression that there is a stricture

of the internal os; but the hard margin of the growth will dispel any such illusion.

Having faithfully tried the means of diagnosis just described, and in the order given, i.e. abdominal palpation, careful bimanual examination both vaginal and rectal, and the whalebone probe, the physician may be still in doubt as to whether the myoma projects into the uterine cavity sufficiently to warrant operative interference through the vaginal orifice, when the tumor cannot be felt presenting in the cervical canal. Under these circumstances, it is necessary to dilate the cervix with tents, or a steel dilator; press the uterus down from above, steady it below with volsellum forceps fixed in the cervix, and make a thorough digital examination of the uterine cavity, noting the attachment and projection of the myoma, the thickness of the endometrium over it, as well as pulsating arteries, if any, in the latter, which would be divided by incising the capsule.

On introducing the finger, what seemed to be a large myoma may prove to be a polypus which is readily removed.

Considerable hæmorrhage may follow so much manipulation; but irrigation with hot water, the application of iodine, and the vaginal plug will control it. The patient must be put to bed, and kept perfectly quiet till all soreness has subsided.

It is hardly necessary to add that, when there is considerable pelvic inflammation present with a myoma, the former must be cured before it is safe to attempt any operation or examination which the patient cannot readily endure without ether.

The following table may be of assistance in diagnosing the variety of uterine myoma:

<i>In Sub-mucous Myomas.</i>	<i>Interstitial Myomas.</i>	<i>Sub-peritoneal Myomas.</i>
<p>The hæmorrhage from the uterus is quite profuse, the more so in proportion to its projection into the uterine cavity.</p> <p>Pain is slight.</p> <p>If there is a hard, firm, well defined tumor, uniform and <i>symmetrical</i> in shape, which has been slowly growing for three years or longer, it is probably a fibrous polypus, or sub-mucous myoma.</p> <p>The uterine cavity is enlarged, filled, and distended by the tumor, which is felt by the finger after dilatation of the cervix. Its attachments can also be ascertained by the whalebone probe.</p> <p>The sub-mucous growths have more cellular, and less muscle tissue; they grow more rapidly than the other forms.</p>	<p>There is some hæmorrhage, but, as a rule, not so much as in sub-mucous myomas.</p> <p>Pain is more severe than in the former case.</p> <p>The growth, in about half the cases, is on the posterior wall of the uterus, which is not <i>symmetrically</i> developed, but bulges a little on one side at the side of the tumor.</p> <p>The uterine cavity is deeper, and more or less tortuous from the bulging of the tumor into the cavity.</p> <p>There is a larger proportion of muscle tissue, and the tumor grows more slowly.</p>	<p>There may be slight hæmorrhage, but more often none, especially if the tumor is pedunculated.</p> <p>Pain is often a very marked, though not an invariable symptom.</p> <p>Marked asymmetry between uterus and tumor. If there are several developing under the peritoneum, the uterus has a knobby outline. If the tumor be pedunculated, it is movable in proportion to the length of the pedicle, unless there are adhesions.</p> <p>The uterine cavity seldom has a greater depth than three inches, and is not proportionate to the size of the tumor unless the latter drags the uterus high up, and so lengthens the cavity.</p> <p>The muscle tissue is most marked in the sub-peritoneal. The tumor develops slowly, and is hard, having almost a cartilaginous feeling.</p>

THE DIFFERENTIAL DIAGNOSIS OF MYOMAS FROM PREGNANCY, EXUDATION  
IN CELLULAR TISSUE, HÆMATOCELE, COLLECTION OF FÆCES.

In all these, the history of the case, its duration, and present symptoms, are directly opposite to those common to uterine fibroids.

<i>Pregnancy.</i>	<i>Myoma.</i>
<p>"Tumor" of short duration.          "Tumor" elastic to touch.          Amenorrhœa.          Usual symptoms of pregnancy.</p>	<p>Of long duration.          Tumor very hard.          Uterine hæmorrhage.          Symptoms of pregnancy wanting.</p>
<i>Cellulitic Exudation.</i>	<i>Myoma.</i>
<p>History of pelvic inflammation.          Exudation sensitive and immovable.          Exudation of short duration, and          distinct from the uterus.</p>	<p>No history of pelvic inflammation.          Tumor not sensitive, and movable.          Tumor of long duration, and in-          timately connected with the uterus.</p>
<i>Hæmatocele.</i>	<i>Myoma.</i>
<p>Formation rapid, and attended by          symptoms of collapse.          Fluctuation and immobility of tu-          mor.</p>	<p>Formation slow, without symptoms          of collapse.          No fluctuation, and tumor mov-          able.</p>
<i>Collection of Fæces.</i>	<i>Myoma.</i>
<p>It is left-sided.          Short duration.          Can be indented by the finger.          Does not move with the uterus.          Symptoms of intestinal obstruction.            Functions of uterus not affected.</p>	<p>Not limited to any side.          Long duration.          Cannot be indented.          Moves with the uterus.          No symptoms of intestinal obstruc-          tion.          Marked disturbance of the uterine          functions.</p>

## THE DIFFERENTIAL DIAGNOSIS OF MYOMAS FROM

<i>Uterine Flexions.</i>	<i>Cancer.</i>	<i>Ovarian Tumors.</i>
The sound enters the uterine cavity in the center of the supposed tumor. If a myoma is present, the sound passes by it into the uterine cavity, which does not correspond to the center of the tumor, but lies in a different direction.	Cancer of the fundus uteri is very rare. Its progress is much more rapid than a myoma. The discharges from the uterus are extremely offensive. Pain in the pelvis, and fixation of the uterus, are quite constant symptoms.	Are seldom connected with the uterus. There is a wave of fluctuation on palpation, and their development is unilateral, and more rapid than myomas. Puncture with a fine needle of the aspirator draws off a fluid showing the characteristic granular cells. Where an ovarian tumor is firmly attached to the uterus, differentiation is often impossible, especially if the tumor be solid.

*The Prognosis* for myomas is fortunately favorable, so far as life is concerned. Very few women die in consequence, though they may be bedridden for a long time. After the menopause, the tumor often gradually diminishes to a remarkable degree, undergoing a change similar to involution of the puerperal uterus, and ceases to be a source of danger, though its presence may be annoying. Myomas scarcely ever threaten life, except from the loss of blood occasioned by them.

*The Diet* is important, and should be so regulated as to nourish the system in spite of the constant drain. Milk, eggs, beef juice, or raw meat extracts, mutton chop, etc., are important articles of food. Great success in the treatment of uterine myomata has been claimed by Dr. Salisbury's method. It consists essentially in drinking a pint of hot water very slowly an hour or two before meals, and half an hour before retiring. The object of this is to cleanse the stomach before eating and sleeping. The muscle pulp of steak, cut from the center of the round, is broiled, seasoned to taste, and made an exclusive article of diet. All the



connective tissue is removed by chopping the beef without stirring it. The fibrous tissue is driven down on the board, while the muscle pulp is occasionally scraped off the surface with a spoon during the chopping, and prepared for eating as above. This treatment must be rigidly adhered to for one to three years to be successful. It has received much commendation from good authorities, such as Drs. Graily Hewitt and Marion Sims, while others have never seen any benefit result from it. Indeed, so little confidence is placed in it that it is scarcely mentioned in recent gynecological literature. The theory that it avoids so far as possible the eating of elements forming the tumor is wholly false. It merely gives a wholesome article of food, and in this way may nourish the patient. Some physicians believe they have seen benefit from wearing an earth poultice, or from the application of myro-petroleum to the abdomen, over the tumor, for a number of consecutive months.

*The Treatment* of myomas of the uterus is too often unsatisfactory. Except where life is in actual danger, or the tumor easy of access, as in sub-mucous myomas and fibrous polypi, it is the better plan to adopt a palliative course, rather than surgical interference, in the hope that the patient will tide over the menopause. It is of great importance to correct a retroversion or prolapse of the uterus, as this favors congestion, and a much more rapid growth of the tumor.

Uterine hæmorrhage is the symptom which is the most dangerous to the patient, the most difficult, and most important to control. This can be accomplished in many cases by a carefully selected remedy, the hot-water douche, curetting the uterine cavity, and the local application of the tincture of iodine or the perchloride of iron to the uterine cavity, the vaginal plug, thorough dilatation of the cervix with laminaria tents, or a combination of these measures. On the least appearance of a show, the patient should lie down with the hips raised a little, and remain in that position till

the flow ceases. In the interval between the periods, moderate exercise in the open air, sun-baths, and bathing followed by vigorous friction of the skin, are excellent to maintain the general health. There should be no constriction of the waist, or pressure on the abdominal organs by the clothing, as it interferes with free venous circulation, and thus promotes hæmorrhage. The tendency to constipation can be obviated by regulating the diet; and an occasional collection of fæces removed by enemas, given to the patient, if necessary, in the knee-chest position. The mineral waters of Kreutznach, in Rhenish Prussia, are quite celebrated for the treatment of uterine myomata.

Electrolysis has had its advocates from time to time, but has not been generally accepted as a reliable method of treatment for all cases.

The hypodermic injection of ergot has been much used to check the hæmorrhage, and is said to be very useful in some cases, particularly for those tumors projecting well into the uterine cavity after *the cervical canal has been and is kept dilated*. Dr. Winckle joins many physicians in commending this drug, but warns the profession against its use in large doses, especially in anæmic patients. The use of ergot has also been combined with incision of the capsule, in hopes that the tumor might become pedunculated, and more accessible for removal. This, however, is often impracticable in interstitial myomata.

Next to ergot, Dr. Winckle recommends *hydrastis canadensis* in twenty-five drop doses of the fluid extract three or four times a day; and if gastric disorder ensue, to use thirty-seven and a half grains of the dry extract in pill form instead of the fluid extract. These may be considered large doses. Fellner believed it caused uterine contractions, and increased the blood pressure. Schatz, who introduced the remedy, thinks it causes contraction of the capillary vessels instead of the uterus, and differs from ergot in this respect. Both Wilcox and Jermnas have found it very useful

for uterine hæmorrhage from other causes than the presence of myomata. Falk has made a careful study of the use of *hydrastis canadensis* for uterine hæmorrhage, and believes the active ingredient is hydrastinin. He uses a ten per cent. aqueous solution, and injects hypodermatically half a dram to one dram twice a week in the inter-menstrual period, and every day if necessary at the time of the hæmorrhage. He reports twenty-eight cases in which hydrastinin was employed with varying success. In some instances it arrested hæmorrhage after ergotin had failed.

In my recent visit to Hamburg Dr. Prochownik assured me that he found the fluid extract of cotton-root an almost infallible remedy for the hæmorrhage due to myomas, and had employed it in many cases with complete success.

*General Considerations for Surgical Treatment.*—While it is true that women seldom die in consequence of the myoma, it is also true that the various forms of local and internal treatment are sometimes inefficient, and dangerous symptoms may arise which require surgical interference to save life. Hæmorrhage is almost always the complication which requires even desperate measures, and the help of the surgeon must not be delayed till after the vitality of the patient has been sapped by loss of blood. This uterine hæmorrhage has no correspondence with the size of the tumor. It is not uncommon to find large tumors without hæmorrhage of any significance, and frequently small tumors no larger than a chestnut may cause an alarming loss of blood.

It is evident that operative measures must differ according to the size and situation of the tumor, and will also be influenced by the condition of the patient. The various operations will also differ in their mortality, and so far as practicable the safest method deserves the preference. The pedunculated sub-mucous myoma is often removed so easily and with so little danger, it is better to remove it at once, even if the patient has no threatening symptoms.

The same symptoms in other forms of myoma might not furnish any indications whatever. The age of the patient is also to be considered. It sometimes happens, though rarely, that the myoma does not develop till after the menopause, and then the operation is likely to become necessary, if the tumor grows rapidly, even if there be no bleeding. As a rule, the myoma ceases to grow after the menopause, and then undergoes a form of involution similar to that following confinement. It usually shrinks somewhat, and may even disappear if the tumor be small.

If, therefore, a myoma is not found till about the age of forty-two or after, it is often possible to control the hæmorrhage till after the climacteric, and then the patient is usually out of danger; while the same conditions in a younger woman—about thirty-five years of age—might render an operation necessary, particularly if the tumor were growing rapidly, or causing profuse bleeding. Hæmorrhage is always a serious symptom, and should never be allowed to approach the danger line, as indicated by the conditions mentioned below, which furnish contra-indications to operating. Other things being equal, the average chances for recovery after surgical interference are rather better for women under forty than over that age.

The following may be considered indications for surgical interference:—

I. Sub-mucous myomas projecting into the cervical canal, and dilating it.

II. Severe, persistent hæmorrhage, not to be controlled by other treatment.

III. Extreme size of the myoma, especially if due to cystic degeneration.

IV. Rapid growth, particularly in young women.

V. Serious invalidism and inability to earn a living. This may force a poor woman to an operation which a wealthy woman occasionally might avoid.

VI. Disease of the tumor itself, such as suppuration or malignant degeneration.

VII. Pregnancy sometimes causes extremely rapid growth, or the tumor may be so situated as to demand removal in preference to the Cæsarian section.

VIII. Pressure symptoms, from the presence of the tumor in the small pelvis, or from interference with the circulation or other functions of the body. A very movable and hard myoma may sometimes cause ascites, which can only be cured by the removal of the growth.

There are, however, certain conditions in which the danger of an operation is so great as to contra-indicate interference, even though the case may seem very urgent. Extreme pallor of the skin and mucous membranes, with a drawn or haggard expression of countenance, denotes a degree of prostration unfavorable to recovery. This is particularly true of suppurating fibroids, and the operator will do well to be very cautious about operating on such patients without first improving their health. A more important contra-indication to operating is degeneration of the heart muscle.

This may take place rapidly, and at an early period. It may be brown atrophy, fatty degeneration, or anæmia, and the muscle have a light brown or milk-and-coffee appearance. The first symptom of increasing degeneration is a fine, easily compressible pulse of 90-100, readily excited by slight causes to 120-140, with panting respiration or desire for air, and anxiety. The appetite is diminished, the patient restless and sleepless. Over the right ventricle, and especially over the right auricle, there is a peculiar bruit, not depending on any valvular disease, but on imperfect filling of the right heart with blood. Any laparotomy under these circumstances becomes an operation of exceeding gravity. Fat anæmic persons, with relaxed, soft muscles, are not good subjects for an operation, but anæmic women with strong, firm muscles will often bear it. A long narcosis is especially prejudicial to the former of the last two classes. A good condition of strength, a healthy,

strong heart and healthy kidneys, are very important for the success of severe operations. The surgical treatment of these tumors may be divided as follows in order of preference, according to the probable rate of mortality and the selection of the operation by the indications as given below :

Enucleation, vaginal hysterectomy, castration, myomectomy.

*Enucleation* is often employed after opening the abdominal wall. The tumor is peeled out of the uterus, the sides of the cavity firmly united by catgut ligatures, and the whole dropped back into the abdominal cavity, like the pedicle of an ordinary tumor. This operation does not imply either removal or mutilation of the uterus.

Enucleation, as used here, refers more particularly to the removal of sub-mucous myomas. Whenever such a tumor presents in the vagina or in the cervical canal, or if in using the sound to ascertain its attachments the tumor is found to have become pedunculated, it should be removed without delay, before the patient becomes exhausted or anæmic from loss of blood. There is scarcely any danger from this operation, and there will be no hæmorrhage from the severed pedicle. It can be accomplished by the *écraseur*, or persistent traction and the use of scissors or Thomas's spoon saw. If the cervix is not dilated sufficiently, use laminaria tents, and if necessary there need be no hesitation in dividing the cervix laterally. If the tumor is not then *readily accessible* for the division of its capsule and enucleation of the myoma or the use of the *écraseur*, it is better to postpone the operation in hopes that by the use of ergot the tumor will be more easily removed. Careful antiseptic precautions are of the utmost importance. After the operation, insert a strip of iodoform gauze in the wound and vagina. This will serve the double purpose of drainage and a good dressing. It must be remembered that small fibroids may remain in the uterus after enucleation of the

principle one, and that consequently a few months or years after it may become necessary to remove a second myoma which has developed and been forced down into the uterine cavity. Vaginal enucleation of a myoma *in the uterine cavity* should not be attempted if the tumor is larger than a child's head. The same sized tumor can be removed, however, if it is in the vagina, or springs from the cervix uteri.

When the tumor is in the uterine cavity, Baker Brown introduced the operation of incising the cervical canal and the os internum, as well as the capsule of the myoma when practicable. This aids the spontaneous enucleation of the tumor by the uterine contractions, especially under the effect of ergot, and in some cases relieves the hæmorrhage when the tumor is well down in the os internum. It has the disadvantage that an incision of the capsule may cause degeneration and suppuration of the tumor, with the danger of septic infection. Myomas have a very limited blood and nerve supply, and readily suppurate from slight traumatism or interference with the circulation in the capsule. The interior of the tumor has practically no blood-vessels. The existence of a central nutritive artery has been asserted, but Roesger was unable to find it in a careful examination of a number of specimens.

*Suppurating Myomas* demand immediate removal, except in some cases where the suppuration has been caused by the negative galvano-puncture, when removal by laparotomy may be postponed if the discharge of pus is slight. Such cases may recover without an operation by following the ordinary treatment for suppuration under other circumstances. When suppuration of a myoma occurs spontaneously, the tumor is almost always of the sub-mucous variety, If the strength of the patient permits, there should be no delay in removing the decaying mass, which is usually most pronounced on the lower portion of the periphery of the growth. A strong Simon curette is an excellent instrument for the purpose. If the entire tumor can be easily removed,

it should be done ; but if not, or if the patient is very weak, it is better merely to remove rapidly the sloughing portions, irrigate thoroughly with permanganate of potash, make the operation as short as possible, and repeat it at intervals of a week or ten days till the entire mass is removed.

Great caution is necessary in operating on these cases when the pulse is rapid and weak, and the skin and mucous membrane appears pale and bloodless. It is a question in such cases whether it is not better to employ antiseptic injections, curette only sloughing portions easily reached without taxing the patient, and endeavor to nourish the system rather than, the vitality is so low, to submit her to what would be otherwise a simple operation. Suppuration of a myoma increases the danger of its removal.

*Vaginal Hysterectomy* is an operation in which it is sometimes difficult to say whether or not castration is preferable. Leopold prefers total extirpation of the uterus by the vagina under the following circumstances :

I. If all other treatment has been tried in vain, and health and life are threatened from hæmorrhage, pain, pressure symptoms, inflammatory or degenerative changes in a single or multiple myoma, not larger than an infant's head.

II. If after careful examination the ovaries are inflamed on one or both sides, and too firmly adherent to perform castration.

III. When the patient is so weak as to make laparotomy questionable.

Vaginal extirpation of the uterus is a thorough operation. Only a small opening is made in the abdominal cavity, which provides good drainage ; the intestines are not cooled ; the strength of the heart is not taxed as much as in a laparotomy ; it does not last much longer than castration, and is shorter than a myomotom y ; finally, it avoids the possibility of ventral hernia. It is therefore preferable to a laparotomy for anæmic women when a thorough operation is necessary. It has, however, the absolute requirement



that the tumor must not be larger than a baby's head ; and the larger the growth, the more difficult is the operation.

*Castration*, i.e. removal of the ovaries, is worthy of careful consideration for anæmic women when the tumor is as large as an infant's head, and the necessity for an operation depends chiefly on the hæmorrhage and rapidity of growth.

The operation should not be performed when the hæmorrhages do not correspond to the menstrual period, or if they are not aggravated at that time, or if the menopause has arrived. It is better adapted to small and rapidly growing tumors accompanied by profuse hæmorrhages, than to large myomas. In the latter the ovaries are sometimes found and removed only with great difficulty.

When castration is impracticable, or if myomotomy appear too formidable an operation, it may be well to consider the proposal of Rydygier to simply ligate the internal spermatic arteries, the uterine artery, and the round ligament, and then close the abdomen. He reports a case successfully treated in this way.

The operation of castration dates from 1872, when Professor Hegar, in Germany, and Dr. Battey, of Georgia, advocated removal of the ovaries for the relief of various affections, among them uterine myomata accompanied by profuse hæmorrhage. As this is one of the conservative surgical measures, it has found much favor. Dr. Wiedow has collected the records of one hundred and forty-nine operations of castration for uterine myomata. Fifteen of them ended fatally. In seventy-six cases the final results were as follows:

Atrophy of the tumors and menopause.....	54 cases.
Occurrence of the menopause only.....	7 "
Atrophy of tumors only.....	2 "
Diminution of bleeding and atrophy.....	6 "
Menopause for three months followed by expulsion of tumor	1 case.
Irregular, slight hæmorrhages.....	2 cases.
Irregular, severe hæmorrhages.....	1 case.
Immediate good results followed by severe bleeding and growth of the tumors.....	3 cases.
Mortality of the one hundred and forty-nine operations..	10 per cent.

More recently Dr. Wiedow has reported sixty-six cases from Professor Hegar's clinic, with five deaths,—a mortality of 7.6 per cent. Four of these deaths occurred with the first twenty-four operations. For the sake of greater accuracy for remote results only those cases are mentioned which have been under observation three or more years after castration. These number thirty-seven,—

Menopause immediately after the operation . . . . .	21
Menopause with occasional bloody discharges. . . . .	15
Flow ceased for six months, and then regular weak periods. . . . .	1

Twenty-four out of thirty-three large myomas entirely disappeared; eight tumors underwent marked diminution, and only one showed no decrease. In view of these excellent results, extirpation of the myoma is reserved at that clinic for peduncleated sub-serous or sub-mucous tumors, fibrocystic tumors, and these of extremely large size.

Some cases continue the same pains and other symptoms due to uterine myomas after the operation as before. Dr. Gusserow believes castration "leads with great certainty to an arrest of hæmorrhage, provided the uterine tumors are not too large, and not in a condition of cystic degeneration"; besides, it is a much safer operation than extirpation of the tumor. Dr. Leopold and others praise the operation, and report good results. Dr. Homans of Boston has found that the bleeding may continue just as severe after castration; and Dr. Winckel still considers this operation *sub judice* for unoperative myomata with a mortality of fifteen per cent. and a failure for the desired result in twenty per cent. of the cases which recover. This is, however, much more unfavorable than the reports of other operators.

Prochownik has had better results. He reports twenty-two cases of castration without a death. Twelve of these were for myomata, and in these the results were remarkable. The tumors diminished in size; pain and bleeding ceased. All of these growths would have otherwise required supra-vaginal amputation, or enucleation from the uterine walls or pelvic connective tissue. It is interesting to note

that the results of castration for neuroses complicating sexual disorders were not so good when healthy ovaries were removed. Dr. Tait advocates removal of the fallopian tubes with the ovaries, and has met with remarkable success. His unusually low rate of mortality must be largely attributed to his remarkable skill as a surgeon. Unfortunately, it will not always arrest the hæmorrhage, nor can the ovaries always be found.

*Myomotomy*, or the removal of sub-peritoneal myomas by abdominal section, is a formidable operation. The indications for it must necessarily overlap those for castration. They are, briefly, myomas larger than an infant's head, growing rapidly, especially if before the menopause, degeneration of the myoma and the threatening of life by otherwise uncontrollable hæmorrhage, pain or pressure. Myomotomy is more particularly indicated if castration is impracticable, the tumor very large, pedunculated sub-peritoneal, or fibro-cystic. As this is one of the most serious operations known to surgery, the risk should be duly considered, and the chances for probable recovery be based on the average mortality of many operators rather than on the exceptional low rate of some distinguished and remarkably skillful individual.

Myomotomy has been performed with much success by many operators, more especially Schroeder, Martin, Leopold, Sanger, Fritsch, Bantock, Thomas Keith, and Lawson Tait. Martin is the originator of an excellent method for the intra-peritoneal treatment of the pedicle, and has obtained excellent results with it. Bantock may be said to represent the advocates for extra-peritoneal treatment. Both these methods are fully described in the references to these names. Both Sanger and Fritsch have modified the extra-peritoneal method, which is preferred by most operators as being more successful in their hands than Martin's method. The danger from this last operation is from hæmorrhage and septic infection if the uterine cavity has been opened. The merit of the intra-peritoneal method is the rapidity and simplicity of the operation, the speedy con

valescence, and in many cases the preservation of the uterus. It is best fitted for sub-peritoneal tumors with a small pedicle, or if the tumor can be enucleated with not more than a very small opening into the uterine cavity. If, on the other hand, the uterine cavity is freely opened, the tissue friable, soft, or cystic, and the patient physically weak, extra-peritoneal treatment of the pedicle deserves the preference. Fritsch unites the stump in the median line and stitches it in the abdominal wound, while Hegar allows the rubber ligature to remain, employs hysterectomy pins, and fastens the stump wholly extra-peritoneally. The scope of this work does not permit further discussion of the subject. The following list of operations on myomas by Dr. Leopold will give some idea of their mortality in comparison with one another:

28 Enucleations, 1 death from sepsis .....	0
35 Castrations, 4 deaths from sepsis .....	2
56 Myotomies, 12 deaths from sepsis .....	5
21 Vaginal hysterectomies, 3 deaths from sepsis .....	2

The medical treatment is considered later.

*Fibro-cystic tumors* are quite rare, and chiefly interesting for their close resemblance to ovarian tumors. It is quite probable that very many of those growths described as fibro-cystic tumors of the ovary really originated from muscular fibers in or near the uterus, and not from the ovary. True cysts of the uterus are extremely rare, and all fibro-cystic growths are the result of a cystic transformation in myomas, which may take place in various ways, but chiefly from separation between muscular fibers, the collection of serum, or rapidly proliferating cellular elements, in the space thus formed, and the fusion of many cavities into one. This is most common in sub-peritoneal varieties, and less frequent in the interstitial ones.

Their symptoms are the same as those accompanying myomas of the same size, excepting that hæmorrhage is not so common with the fibro-cystic tumor.

The differential diagnosis is extremely difficult, and often impossible. The most distinctive feature is a localized

obscure sensation of fluctuation without the hardness of a myoma. If an aspirator be used, a variable amount of fluid is drawn off which leaves solid portions of the tumor in the abdomen; this fluid coagulates spontaneously, and closely resembles the liquor sanguinis; under the microscope, it shows a few epithelial cells, oil globules, and fiber cells, characteristic of the structure in which the cyst originated. The granular ovarian cell, or Drysdale's corpuscles, peculiar to ovarian tumors, are not present. The microscopic appearance of the fluid is the best guide in case of doubtful diagnosis. Emptying the cyst by trocar or aspirator has not been attended with much success as a method of treatment. As an almost invariable rule, they must be treated in the same way as uterine myomas. They develop earlier in life than ordinary myomas, grow rapidly, and call for immediate removal if the strength of the patient will warrant such a formidable operation.

*Uterine Polypi* (adenoma) are divided into three classes: cellular, glandular, and that known as fungoid endometritis. The first is the most frequent, and it is covered with mucous membrane, which gives to it the common name of mucous polypus. It is generally situated near the internal os, and seventy per cent. of the cases occur between fifty and seventy years of age. Its texture is soft and vascular, like a nasal polypus.

The glandular polypus consists in a hypertrophy of the cervical follicles or Nabothian glands, and is commonly associated with laceration of the cervix. The various enlarged follicles are united to one another, so that the polypus may resemble an hydatiform mole.

Fungoid (polypoid) endometritis has been mentioned in a previous chapter, but further consideration of it is necessary. It may be merely a hypertrophy of the membrane lining the uterine cavity, with moderate dilatation of the utricular glands, and affect the entire membrane; or it may occur in localized spongy patches, like soft, flat, wartlike excrescences, which are attached by a broad base to the walls of the uterine cavity. In more rare cases, the utric-

ular glands of the uterus participate more actively in the new formation, leading to diffuse glandular development in the mucous membrane. This is known as diffuse adenoma of the uterus.

Polypi are liable to develop from any condition causing a passive congestion of the lining membrane of the uterine cavity, and especially from chronic endometritis. They vary in size from a pea to a hen's egg; and all three forms have symptoms common to one another and to uterine myomata, such as uterine hæmorrhage, watery discharges from the uterus, leucorrhœa, pelvic pain, etc. Pain, however, is generally absent in pediculated polypi, which lie in the external os or protrude from it. It is often a matter of surprise that so much trouble can come from such a small growth. The presence of a polypus no larger than a pea may excite profuse menorrhagia, leucorrhœa, etc., which only ceases when the growth is removed. One of these little tumors has been known to act like a little ball valve in the cervical canal, causing both dysmenorrhœa and sterility.

*The Diagnosis* is easy when the growth can be seen or felt presenting in the external os uteri; but when it lies within the uterine cavity, it is a difficult matter, and the presence of a polypus can only be ascertained by dilating the cervical canal, and exploring the uterine cavity with the finger.

*Prognosis.*—The proneness of all forms of uterine polypi to recur after removal, and the enfeeblement of the system due to the hæmorrhage, leucorrhœa, and pain caused by these growths, have led some observers to believe them to be of a malignant character. This applies more especially to endometritis fungosa with diffuse development of the utricular glands. Indeed, specimens of this growth removed by the curette have been examined by expert microscopists, and pronounced without hesitation to be malignant, which the subsequent history of the case proved to be an incorrect diagnosis.

Adenoma and carcinoma are sometimes found in the same specimen, which Ziegler terms adeno-carcinoma. This has led some writers quite recently to believe that an adenoma

may develop into a carcinoma. At all events, adenoma may be considered as on the boundary line between benign and malignant disease, which can be determined only by the subsequent history of the case, as the microscope does not give us sufficient light on the subject. While circumscribed pediculated polypi may recur frequently, they are not at all likely to assume a malignant character. The same cannot be said, however, concerning the endometritis fungosa, i. e. general or local hyperplasia of the mucous membrane of the uterine cavity, involving the utricular glands as described above. The frequency of recurrence, the extent of the disease, and the depth it penetrates into the uterine wall, indicate malignancy in proportion to the prominence of these symptoms; while Dr. Goodell adds an important clinical observation, that "malignant diseases of the endometrium are usually found in old maids and in sterile women, while malignant diseases of the cervix almost always occur in women who have borne children."

*The Treatment* is obvious. When one of these little growths is seen in the cervical canal, seize the pedicle with dressing forceps, and twist it off. In rare instances it may be so large that an *écraseur* must be used. Nearly all the small intra-uterine polypi can be crushed down and removed by the dull-wire curette, which will do no harm; and if a small polypus be suspected, this curette had better be used instead of dilating the canal. If both this and Roux's curette fail, the cervix must be dilated, and the noose of an *écraseur* passed over the pedicle of the tumor to remove it. This latter operation is subject to the same risks as the removal of a sub-mucous fibroid, and is not to be performed without due consideration. It is a cardinal rule that all manipulations of any kind in the pelvis must be carefully avoided when there are any symptoms of pelvic inflammation. These growths do not cease to develop after the climacteric, and are liable to return after removal. Only a short time ago the writer removed a glandular polypus from an old lady who said she was seventy-two years old.

In endometritis fungosa, the cervix must be dilated, un-

less it is sufficiently relaxed from the frequent hæmorrhages and all the diseased tissue be thoroughly removed with Roux's curette. The uterine cavity should then be injected with iodine or the undiluted perchloride of iron, taking great care that the cervical canal is sufficiently patulous to allow a free escape of the fluid injected. In cases of frequent recurrence, when the above treatment has failed, fuming nitric acid, or the solid nitrate of silver, has been used. This very severe treatment should not be employed until all other remedies have failed, except removal of the uterus. The latter is best done by the operation known as vaginal hysterectomy, and is indicated if, in spite of all other measures, the growth becomes of a malignant character, and nests of epithelial cells and atypical formations are observed under the microscope.

*The Medical Treatment* of uterine fibroids, fibro-cystic tumors, and uterine polypi is considered under one heading, as the same remedies apply to any one of them, if indicated by the symptoms. Unfortunately, it is doubtful whether any remedies have any power of directly causing the tumor to be absorbed, or expelled from the uterus. The growth and the attending hæmorrhage are sometimes checked or arrested, so that the patient passes safely through the climacteric, and suffers little inconvenience afterwards. Cases are reported where the tumors diminished in size under treatment; but as many of these are at the menopause, it is a question to which the result was due. Even if there be no perceptible improvement in the actual size of the tumor, if the pain and hæmorrhage can be sufficiently controlled by remedies till after the climacteric, it is a far better course to pursue than to submit the patient to a dangerous operation. Consult also the chapter on Menorrhagia and Metrorrhagia.

#### THERAPEUTICS.

*Belladonna*.—Plethoric patients. *Much bearing down in the pelvis* (lil. tig., natr. mur., plat., *sepia*). Menses too early and too profuse; bright red blood; or thick, decomposed, dark red blood. *The blood feels hot to the parts: throbbing and sensitiveness* to the touch in the pelvic organs.



*Calcareæ iodide*.<sup>1</sup>—*Patients having a strumous diathesis.* Menses too early, too long, and too profuse; milky leucorrhœa, with itching and burning; acidity of the stomach; profuse perspiration in the morning (quinizæ sulph., *nitric ac.*, phos., rhus tox.), and on slight exertion. It must be prepared fresh, and kept in a blue glass bottle, out of the light. The writer has had two cases in which *calcareæ carb.*, 3 x. trit., seemed to diminish the size of the tumor to a marked degree. One was about the size of a cocoanut, in the left side of the pelvis, and seemed to partake of the characteristics of both a myoma and ovarian tumor, though the symptoms pointed to the former rather than the latter. The second one was a distinct sub-peritoneal myoma, about the size of a man's fist, on the anterior wall of the uterus. In less than two years the growth had so decreased in size it could hardly be found by the most careful bimanual examination.

It is by no means claimed that *calcareæ* is the sovereign remedy for myomata. Only, it seems one of the most promising ones, if its use is persisted in long enough; but there are very many cases in which it will be of no service.

*China*.—Is excellent for the prostration accompanying the loss of blood; also for uterine hæmorrhage of dark blood and clots, fainting, and muscular twitching.

*Ferrum*.—Anæmia from loss of blood; stinging headache

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<sup>1</sup> The indications for this remedy in the treatment of uterine myomata are not well understood. It seems to be more often effectual in causing a gradual diminution of the tumor than any other remedy, and in doses too small to act on the theory of calcification of the growth and interference with its nutrition. It is significant that the most celebrated mineral waters for the cure of fibroids contain a large amount of lime salts. Good results have been reported from the third decimal trituration. It has also been recommended in the shape of ten grains to a pint of water, a teaspoonful to be taken after each meal, gradually increasing to a tablespoonful. This may act very similar to the chloride of calcium in possibly causing a calcarerous degeneration in the tumor; but as it has been found that the coats of the arteries are also likely to undergo the same degeneration, the remedy may become a dangerous one. It seems quite probable that it can influence the nutrition or development of these tumors in a certain number of cases, without being given in sufficient quantity to produce the degeneration alluded to.

and ringing in the ears before the menses ; flow too profuse, passive and dark, accompanied by labor-like pains in the abdomen, and a glowing red face.

*Platina*.—*Menses too early, and too profuse* ; flow dark and clotted, with much bearing down and pinching pains in the abdomen ; nymphomania ; painful sensitiveness, and constant pressure in the hypogastric region ; the body feels cold, excepting the face.

*Sabina*.—*Menses too early, too profuse, and last too long* ; hæmorrhage from the uterus in paroxysms ; worse from motion ; blood dark and clotted, and sometimes offensive ; with pain from back to pubis.

*Secale*.—This should be freshly prepared, and will be found to act best in the tincture, or lower dilutions. *Menses too profuse, and last too long* ; uterine hæmorrhage, worse from least motion ; discharge thin and black ; black, lumpy, or brown fluid, and very fetid ; pains in the uterus of an expulsive character.

*Trilline*.—*Metrorrhagia*, especially at the climacteric, flow returns every two weeks. It may be active or passive, and is accompanied by pain in the back, and cold limbs. Dr. Ludlam speaks highly of this remedy for the hæmorrhages resulting from myomata, and thinks it most useful in those cases where the muscular fibers of the uterus have been decidedly developed by pregnancy or otherwise.

The following remedies may be consulted for further reference :

*Ars.*, *aurum*,<sup>1</sup> *carb. veg.*, *cinnamon*, *conium*, *crocus*, *cyclamen*, *gossypium*,<sup>2</sup> *erigeron*, *hamamelis*, *iodine*, *lach.*, *lycop.*, *mag. mur.*, *mercurius sol.*, *nitric ac.*, *phos.*, *sepia*, *silicea*, *sulph.*, *thuja*, *ustilago*, *vinca major*.<sup>3</sup>

<sup>1</sup> Dr. Schwabe considers this the chief remedy, especially the *aur. mur. natr.*, to promote resorption. Like other remedies, it must be used perseveringly.—*Lehrbuch der Hom. Therapie*, 3d ed., vol. ii., p. 992.

<sup>2</sup> Dr. Garrigues recommends the cotton root for the treatment of the hæmorrhage.—*Medical Record*, vol. ii., p. 554, 1885.

<sup>3</sup> Recommended by Dr. Meadows for the hæmorrhage of fibroid tumors.—*Lancet*, July 12, 1873.

## BROMIDE OF GOLD IN EPILEPTIFORM DISORDERS, PARTICULARLY OF CHILDREN.

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BY

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Two years ago I called attention to the use of this salt in epilepsy. In my paper on the "Unknown Iodides," read before the American Institute in 1889, I showed that when given in cerebral disorders, the auric bromide must be selected from the symptoms of both gold and bromine, as we have no provings of the drug.

Since then, European physicians have made further experiments with the medicine. In a Russian medical journal a case of hysteria gravis—which resembled epilepsy—is reported, in which the auric salt of bromine proved highly beneficial after many remedies had signally failed. Prof. Danillo, of St. Petersburg, has recently published a number of cases, in most of which the bromide of gold in doses of  $\frac{1}{4}$  grain was promptly efficacious in arresting the epileptic seizures. These curative effects cannot be attributed altogether to the bromine, because that drug is present in this salt only fifty-five per cent. by weight, and in  $\frac{1}{4}$  grain the bromine would exist as only  $\frac{1}{8}$  grain, while in the effective dose of bromide of potassa (20 grs.) there are nearly 12 grains of bromine!

As a remedy for hysterical spasms and epileptiform attacks, gold is the equal of bromine and its salts. The combination, at first thought, strikes one as singular. Nearly all the primary symptoms of the bromides are the opposite of those of gold, for the former contracts the blood-vessels of the brain, and the latter dilates them. Bromide of gold, then, is the union of two opposite acting drugs, and, according to the teachings of all schools, ought to antidote each

other, which they certainly do not do, or no curative results would be obtained from its use. There is much to be investigated in the action of opposing drugs when united. But the brilliant results of the union of digitalis and belladonna, and digitalis and glonoine, give us a clue to their action, and how opposing drugs may be made useful.

This paper was written to illustrate the value of bromide of gold in one of the nervous disorders of children—"night terrors." Until lately this affection has been supposed to be mainly mental, or due to terrifying dreams. But recent investigations are inclined to the opinion that they are epileptiform. Their causes are not always in the brain, but oftener, perhaps, in the gastro-intestinal canal, and due to exaggerated reflex action.

CASE I.—A delicate, blonde female child, of very neurotic parentage, had been the subject nearly every night of violent attacks, during the hours before midnight, of "terrors." She would waken suddenly with a sharp scream and mutter incoherently; was unconscious for several minutes, during which time she had stiffness with clonic jerking of the whole body; *no* trismus or frothing at the mouth. She had been treated by an accomplished woman physician—for worms—and with carefully selected remedies, but with only slight relief. I prescribed cimicifuga, based on the high recommendation of some physician who had been very successful in its use, although there are no symptoms in its pathogenesis which appear to call for it. It modified the attacks, but only for a short time.

Then bromide of gold, 1c trituration, was prescribed in 2-grain doses, three times a day. After two weeks of its use, the nurse informed me that the child's sleep was undisturbed, and that the paroxysms gradually became lighter. One dose a day was given for two weeks, then suspended. Several months after the nurse said the attacks had not returned.

CASE II.—A nervous child, aged ten years, one of whose

parents had slight epileptic attacks and the other was subject to hemicrania. This child was old enough to describe her sensations. She said she had a dream of suffocation, wanted to scream but could not, and was not conscious of waking; only became conscious when she found some one holding her, who had rushed to her when hearing her scream. There was no real spasm, her mother said, but strange, aimless struggles. The paroxysms occurred two or three times a week. She had taken many drugs with no effect.

*Prescription.*—Bromide of gold 1c trit., 5 grains three times a day. Three weeks after, report that the attacks grew less frequent and violent. Six weeks—on one dose at night—they had ceased, and have not returned after several months.

In epilepsy, or similar paroxysms, in adults, I would advise, if the 1c fails, to use one grain of the  $\frac{1}{10}$  trit., three times a day.

I have used the 1x ( $\frac{1}{10}$ ) one grain every four hours, in a case of exophthalmus with violent congestion of the head, with excellent results. In similar doses it benefited all the symptoms of typical cases of that disorder.

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## ELECTRICITY IN GYNÆCOLOGY.

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BY

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It is not many years since it was thought that electricity was calculated only to rend trees, split granite, and to kill people in thunder-storms; while others, more thoughtful, believed that in the wonderful commotions which took place in the skies, noxious vapors were destroyed and ozone was liberated, giving new life to every living thing, and making the pulse of mankind beat with renewed energy, dispelling

the gloom that hovered over a community, caused by an unhealthy condition of the atmosphere.

It is since my time that it was thought useful only for telegraphing and electrotyping. But see the change which has taken place during the last few years. By its means we can communicate with each other hundreds of miles away, with voices so natural as to be easily recognized. The phonograph repeats the words long after the lips that uttered them have been silenced, and in such natural sounds that we feel we are conversing with those who have crossed the Great River. We have only to turn a button and the ponderous wheels of machinery move the industries of the world; or touch another, and night is turned into day. And while these discoveries with many others have been developed in the arts and sciences, the medical man has not been idle. In place of the batteries of many years ago, which for intensity were so powerful that one could hardly withstand their shocks, they are now made so delicately that the weakest child can bear their influences with pleasure. Its power can be so graduated and measured that we know to a certainty how much we are administering as when we weigh our doses of any other kind of medicine.

In no class of diseases has the advancement taken such rapid and wonderful strides as in gynæcology. Without it, now, the physician should never think of making a specialty of any of these disorders. He should be well equipped with the best galvanic and faradic batteries, and in a large practice the static also is indispensable. And no one should have the hardihood to undertake the use of the galvanic current in these troubles without a good milliampèremeter. This is of as much importance as the scales of the druggist in dispensing poisons. It is not of so much importance in using the faradic current to bear in mind the application of the different poles, for the to-and-fro movement caused by the "cut off" changes it from the constant current. Yet I am inclined to think that the positive pole is the more

soothing,—is more of a sedative than the negative, and that, as in the galvanic, the negative has stronger absorbing qualities. The faradic is certainly more serviceable when used to awaken muscular action or nervous sensibilities. But to the galvanic we look for the wonderful curative properties which we expect to obtain. It is, then, to galvanism that I wish to refer more particularly. The positive pole relieves pain, checks discharges of any kind (blood included), acts as an astringent, and has absorbing qualities, though to a less extent, than the negative. The positive pole is a sedative, and acid in reaction; the negative alkaline, and relaxing.

The chemical action can be determined at any time by applying the two poles to a small piece of wet litmus paper. If there is a constant or profuse menorrhagia, the negative electrode placed at the back, and the positive inside the uterus, with thirty to fifty milliampères turned on, the results are perfectly satisfactory, checking the flow and causing a contraction of the uterus. If a bleeding comes from an intra-uterine tumor or hydatid, the tumor will wither or the hydatid will exfoliate. Two to three treatments will usually suffice. If, on the contrary, the negative pole be used inside the uterus the flood-gates would be opened wider, and while it might kill the tumor or hydatid, the flow would be so great that disastrous results might ensue.

Catarrh of the mucous membrane of the uterus, endometritis and endocervicitis are treated in the same way, and these treatments, with the internal administration of the fluid extract of black willow in half-teaspoonful doses three times a day, are positive specifics in *all* cases. The galvanic treatment in these cases should be used every other day, and from two to fifteen treatments will cure.

Subinvolution is treated a little differently. Here the galvano-faradic combination acts better. The positive pole of the galvanic current is connected with the negative of

the faradic, which causes the galvanic current to pass through the wire coil of the faradic. One pole is then attached to the negative galvanic, and the other to the positive of the faradic. Both batteries are then set in action, and we obtain a combined current. The results of these currents are so satisfactory that nearly half of my cases are subjected to this form of treatment. I cannot recommend this too strongly. It has absorbing and tonic qualities that surpass all medicines. It contracts and gives tone to the uterus, and seems to build up the whole nervous system. The physician or surgeon who understands the effects of galvanism on fibroid tumors of the uterus of any character now scorns the knife in removing these formidable and most painful troubles. By using a large clay electrode on the back, and a needle insulated only on the point (made for that purpose), with the negative pole and 250 milliamperes applied, once a week or month, inserted through the vagina or abdomen, the cure is perfected in from two to six months, according to the size of the tumor. Many cases could be referred to where these results have been obtained in my own practice.

Fibroid tumors of the ovaries are treated in the same way, only the pole at the back should be applied over the organ, the clay electrode should be smaller, and the negative should be a small ball pole covered with potter's clay, and this covered again with absorbent cotton fastened with a small rubber band. For this treatment is not claimed a *cure*, but it so contracts the arteries that feed this ovarian tumor, that the growth is stopped. The absorbent qualities are insufficient to remove the growth. I believe that it will also check the growth of encysted tumors, but I am not in a position to speak with any positiveness on this subject.

Pelvic cellulitis is a disease that baffled the skill of almost every physician and surgeon until the galvano-faradic current was introduced. If his patient recovered in a year or



two he congratulated himself on the fact that he had done something wonderful. If the sufferer in that time was cured she was also a happy mortal, and would look back with horror on the past, feeling that she had been rescued from something worse than death, by almost a miracle. Now all is changed, and with the positive pole and clay electrode placed at the back and the small clay electrode just described in the vagina, with fifty to seventy-five milliamperes, and treated every other day, the thickening is dispersed and the heavy weight and pain removed. If there is much inflammation, or if the difficulty is of a more acute character, the poles should be *reversed*.

The hyperæsthesia of the uterus and vagina can better be treated with the galvano-faradic current, the positive pole in the vagina with about ten to twenty milliamperes every other day. In all cases here spoken of the sitting should be from fifteen to twenty minutes.

In chronic inflammation of the uterus the galvano-faradic current is specific.

While we have such a potent agent at our disposal, is it not surprising that we do not study more carefully these remedies for human relief and benefit? Only about twenty-five years ago there was scarcely any literature on the subject, and we then thought that possibly these diseases were imaginary. But alas! our generation feels the neglect, and our women of to-day suffer for the carelessness and ignorance of the doctors of the past.

Stenosis, whether it be in the internal or external os, caused from flexions or atresia, can be cured by the application of the negative pole introduced by graduated electrodes, as in stricture of the urethra.

In dysmenorrhœa, caused from hyperæsthesia, with a suppository composed of belladonna extract and iodoform, of each one grain, introduced into the rectum during menstruation once in two or four hours, and the negative pole with twenty to fifty milliamperes used every third day in the

cervix during the interval, will cure to a certainty. Of course, instrumental assistance is to be used as occasion requires in all flexions.

The batteries I am using are the Waite & Bartlett, of New York. Their wall cabinets and static machines are the only ones I can recommend for use. They are always reliable and never get out of order. They are somewhat expensive, but so satisfactory that the physician is always satisfied with results, and never regrets the expenditure.

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### DYSMENORRHŒA.

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BY

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Mrs. B., a married lady, aged seventeen, is thin, tall, dark complexion, and of nervous temperament. She has been suffering from most excruciating pains during her menses, which appeared at fourteen years of age. She was treated by both allopaths and homœopaths. The latter treatment used to give her a little relief. I was told that *pulsatilla*, given during the pains, used to give her some temporary relief. On the 13th of December, 1888, I was called to see her during her agony. I found her very restless, tossing about in bed and sometimes screaming violently. Her previous history was told to me, from which I came to the conclusion it must have been an ovarian neuralgia. I gave her *xanthoxylum*  $\phi$ , gtt. x, aqua pura  $\mathfrak{z}$  iii; one dessert spoonful was to be given every half-hour. It was to my surprise that the second dose relieved her agony completely, and it did not return again. No medicine was given during the interval. On her next period the pain again returned, but not so violently, and the same remedy was given, which

relieved her promptly. I advised her to take one drop of the same medicine morning and evening for a period of seven days previous to her next courses. This she did, and this time during her menses she experienced no pain; it was quite natural and lasted for five days. She has not had any pain during her subsequent monthly periods. I think I ought to mention here that her monthly courses were not only painful but irregular as to the time and quantity. Sometimes she was a few days previous to her time, at others she was later; as to the quantity of discharge it was sometimes profuse, lasting for a short time; at others, again, the quantity was less and lasting for a longer period, with complete disappearance for a day and reappearing again. The character of the discharge was similarly changeable, sometimes reddish, at others pale, but the most severe pain for the first three days was always present.

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## TARENTULA HISPANA.

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BY

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*Synonym*, Lycosa Tarentula.

*Class*, Arachnida.

*Order*, Dimerosomata.

*Family*, Lycosidæ.

Having in view the frequent misunderstandings arising from confusion of the two tarantulas, we digress from therapeutics sufficiently to point out the zoological characteristics of each of these spiders. We may the more consistently give space to this consideration when we note that the pathogenetic effects of the two tarantulas have nothing in common, Tarentula Hispana being the only one we

have found applicable to diseases of the female pelvic organs.

On the authority of Dr. George Marx, of Washington, who appears to have made a special study of Arachnology, we have it, that, "The tarantula of Europe is the oldest known and best described spider, and it received its name from the city Taranto, in Southern Italy; it was in the middle of the sixteenth century that the inhabitants of that city were alarmed by the sudden appearance of vast numbers of large, dark-colored, hairy spiders in their gardens and vineyards. These fearful-looking animals were hiding under every stone, in every crevice of the walls and rocks, and many gardeners and soil-tillers were bitten in hand or foot by this new fiend. The terror-stricken (more by the horror and fear of the animal than by the actual pain of the bite) sought the aid of the doctors, who decided that, to remove the poison from the system, the patient had to undergo a powerful diaphoretic cure, and recommended constant and continuous dancing as the best-suited medium. The trembling victim was led to the public dancing ground, the guitar, trombone, and clarinet resounded in *prestissimo* measure, and he was seized by one of the swift-footed girls and whirled around until she was breathless, when quickly another daughter of the village took her place, and so on until the poor fellow, bathed in perspiration and perfectly exhausted, fell swooning to the ground. After a couple of hours of sound sleep he was pronounced cured. This dance they called Tarantella.

"Ferrande Imperato wrote the first account of this spider, and his son published it in 1599. He says: 'These spiders are called "tarantuli" because they infest the environs of the city Taranto; the inhabitants call them also "solofizzi," and fear them very much for their venomous bites, which produce great pain and a tremor through the whole body. The effect of the bite reappears the same time every year as long as the unfortunate victim lives,

and the only cure is a powerful perspiration and exhaustion, which is produced by continuous dancing.'

"Writers who followed Ferrande were not satisfied with this description of the effect of the bite of the tarantula ; they exaggerated the symptoms and enhanced the terror until these reached the ridiculous. 'The tarantulati' (victims), says one, 'laugh, cry, dance, sigh, scream, and perform a thousand extravagances ; they cannot bear to see the blue or black color, but they rejoice in the red and green,' etc.

"The superstition about the bite of the tarantula prevails in some districts to the present day, and the naturalist Hoffman gives an interesting narrative of how, in the neighborhood of Naples, the lazzaroni were utilizing this superstition in order to obtain wine or money from the credulous, 'for they suffer themselves to be bitten purposely by the tarantula ; then they raise a big halloo through the streets, and the charitable population gives them wine for the pretended cure ; they drink it in immense quantities, and then commence to dance amid the encouraging and joyous shouts of the people.'

"Ludovico Valetta wrote, in 1706, a treatise on the habits of the tarantula, which he found also in the northern part of Italy. Pallas describes the identical spider from southern Russia. Olearius found it in Persia, Dufour in Spain and Portugal, and Brullé in northern Africa.

"The tarantula of Europe and the eastern hemisphere belongs to the family Lycosoidæ or wolf spiders, genus *Lycosa* or *Tarentula*. The members of this family make no web to live in, but hide under leaves and stones, and catch their prey running ; they carry their egg cocoon along, fastened on the under side of the abdomen by strong threads, and in some genera the young ones, when first hatched, domicile on the back and the legs of the mother, giving her a hideous appearance. Linnæus called it *Aranea tarantula*. Its present name is *Tarentula fasciventris* (Dufour).

"Who has ever traveled through the West India Islands or southern Texas and Florida and has not met with the unavoidable darkey with a tarantula in a box or bottle, offering this curiosity for sale ? They—the darkey and the tarantula—are found everywhere, at steamboat landings, depots, hotels, etc. Examining

ing *this* tarantula we see at once that an entirely different-looking spider presents itself here under the same name.

"This American tarantula is found in all countries of the western hemisphere below the thirty-seventh degree of north latitude, and it belongs to the family Theraphosoidæ, a family which deviates from all other Araneida by having four instead of two lungs, and their mandibles possess movable claws with vertical motion, whereas in all other spiders these claws move horizontally. The largest spiders of the tropics belong to this family, and their poisonous bite is greatly feared by the inhabitants, and certainly with more right than the comparatively harmless Tarentula fasciventris of Europe and the East. Not only that the bite or sting of any animal heals under greater difficulties in a hot climate, but the poison gland of this spider is of such formidable size that if its contents should be introduced into a wound it would certainly show its venomous character in an alarming state.

"I must here, however, state that I have never heard of any authentic case of a serious result of spider bite, and I myself, although having been bitten accidentally and purposely by spiders of considerable size many times, never experienced any greater consequence than considerable local inflammation not much worse than the sting of a bee. However, the intensity of the symptoms will, of course, vary with different individuals. The American tarantula belongs to the genus Thaleromata (Auss.).

"There is a group of Arachnides closely related to the scorpion family, the Pedipalpi or Tarentulæ (Fabr.), and here we have the third tarantula.

"Is it now to be wondered at that mistakes and misunderstandings may happen, when we speak of the tarantula and neglect to mention which one of them we do mean? and now is it clear to the reader why the physiological action of the European spider differs so decidedly from that of the western hemisphere?"\*

In reading up the literature of this subject one cannot but remark the confusion that exists, more especially in reports of clinical cases, the majority of writers failing to designate which of the two tarantulas has been used.

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\* *The Homœopathic Recorder.*

We give the pathogenesis of the drug in relation to our subject so far as we have been able to complete it:

*Bladder.*—Cystitis, with high fever, gastric derangement, excruciating pains and impossibility to pass a drop of urine; the bladder seems swollen and hard; great tenesmus from spasmodic action, debilitating the patient, who passes, only by drops, a dark-red, brown, fetid urine, with a gravel-like sediment.

*Sexual Organs, Female.*—Sexual excitement; lasciviousness reaching almost to insanity; nymphomania. Heat and dryness of the vulva, intense itching of the vulva, worse at night, accompanied by thin, acrid, yellow leucorrhœa. Neuralgia of the uterus with sadness and despair; reflex chorea; hyperæmia and hyperæsthesia of the sexual organs; sensitiveness of the uterus, much borborygmus through the vagina. Pains in the uterus with expulsion of gas, preceded by hysteria. Fibrous tumors of the uterus, with loss of pale blood, and with bearing-down pains. Displacement of the uterus with retention of urine and difficult defecation. Burning pain in the hypogastrium and uterus, with sensation of great weight, interfering with walking, as in prolapsus, and causing pruritis vulvæ. Sensation of great weight, as if there were not space enough in the pelvis with upward pressure. Swelling and induration of the uterus with difficulty in walking. Pain in the hypogastrium and hips as if compressed, unconquerable sleepiness. Menses profuse, followed by pruritis vulvæ. Contraction of the uterus. Dysmenorrhœa with gastric derangement, vomiting and anguish. Profuse menstruation accompanied by frequent erotic spasms; crossness, *ennui*, and deep dissatisfaction; catamenia too early, pain in the lumbar region as soon as menses commence and ceasing with it. Great pruritis in vulva after the menses. Terrible pruritis, a sensation as though insects were creeping and crawling. The outer parts feel as if worms were crawling and boring, with no relief from cold or heat. Constant irritation, which is

annoying and distressing. Leucorrhœa, burning, smarting, and uneasiness in the coccyx, relieved by standing, aggravated by the slightest movement, sitting or lying, or by the least pressure. Coccygodynia.

Tarentula Hispana being distinctly a remedy for reflex disorders there are numerous concomitant symptoms. Thus we have often a long train of nervous symptoms.

*Mental Derangement.*—Sadness, grief, melancholy, moral depression, disgust for everything. Insane paroxysms; she pulls her hair; strikes her head with her hands; general trembling; restlessness of the legs and often sexual excitement. She sings, dances and cries; without fever.

*Hysteria.*—Feigned paroxysms. Laughter immoderate, and in uncontrollable attacks. Sings until hoarse and exhausted. Attacks of suffocation, with crying and screaming. Præcordial anxiety; tumultuous beating of the heart; want of air. Beating of the heart ceasing suddenly, then patient thinks she will die. Heart pains as if squeezed. Mood changeable; quarrelsome, with weak memory, but with excited sexual passion; lasciviousness, with indecent exposure. Hysteria with bitter belching and repeated yawning, relieved by lying down and by music; restlessness of hands and legs; constant movement, cannot remain long in one place; great and constant heat in the epigastrium; disposition to joke and laugh and to play tricks, with impulsive movements; sudden fox-like and destructive efforts, requiring the utmost vigilance to prevent damage, followed by laughter and apologies. Consciousness of unnatural state of mind, hence despondency, sadness, moral depression, moral relaxation, with complete loss of memory; mental chorea, hyperæmia and hyperæsthesia of the female sexual organs.

*Headache.*—Severe headache, aggravated by touch, with sensation as if cold water was poured upon head, with great noise internally; deep intense headache, with restlessness, anguish and malaise, the pains fly to forehead and occi-



put, with photophobia; pain in occiput as if from striking with a hammer, extending to temples; burning, scorching heat in the occiput, extending all over the posterior part of head; great pricking and itching over whole body; convulsive trembling of body; convulsions, paralysis, complete retention of urine and fæces, meningitis (?).

Excessive hyperæsthesia; the least excitement irritates, to be followed by *ennui* and sadness; intense headache as though thousands of needles were pricking into the brain, better by rubbing the head against the pillow; heat of body; indescribable distress in the cardiac region, at times heart feels as if twisted over. Headache as if a large quantity of cold water was poured on the head, relieved by pressure and by rubbing head against the pillow; great distress in cardiac region.

Headache worse on waking; pains as if head was knocked, with stiff neck. Headache accompanied with trembling, oppression of the chest; palpitation of the heart; great nervousness and spinal tenderness, or with uterine symptoms. Constrictive headaches with uterine pains.

*Hysterical Epilepsy.*—Anguish and oppression of the chest, nearly amounting to suffocation; has to move constantly hands and legs, followed by general fatigue; uneasiness without any cause, changes position every moment; burning heat through whole body, alternating with intense coldness that causes trembling and shaking; feet always cold; hysteria with crossness, crying and screaming; profuse urination; physometra; dysmenorrhœa with gastric derangement, vomiting and anguish. Periodicity.

There are many remedies in close relation to Tarentula Hispana in hysteric states and choreic symptoms. Prominent among these related remedies the late Prof. Farrington says: "We may profitably study the following. Compare tarentula with:

*"In choreic symptoms: ACTEA RAC., STRAMON., Hyosc., Crocus,*

AGARICUS MUS., *Caust.* (Mygale is comparable with the same remedies.)

"*Hysterical symptoms* : IGNATIA, MOSCHUS, Stram., *Plat.*, *Hyosc.*, Bellad., Nux mosch., Nux vom., Laches., Phos., Zinc., Origanum, etc.

"Of these STRAM., IGNATIA, HYOSC., and Bellad. are most similar in the mental symptoms ; MOSCHUS, IGNATIA, *Laches.*, in suffocation ; MOSCHUS, PLAT., *Zinc.*, *Hyosc.*, *Stram.*, Phos., Origan., in sexual excitement.

"In the constrictions of the uterus, head, heart, etc., so prominent in TARENTULA, the following are nearest related : BELLAD., *Secale*, CHAM., IGNATIA., NUX VOM., PLAT., LACHES., *Sepia* (uterine) ; CACTUS, *Lil. tig.*, Agaric., LACHES., *Nat. mur.*, Nux mosch. (heart).

"*Hyperaesthesia, general* : BELLAD., HYOSC., *Nux vom.*, *Cinchon.*, Natr. mur., *Sepia* ; Agaricus, *Actea rac.*, Stram. (the last three of spine).

"*Restlessness of the legs* : *Ammon. carb.*, *Actea. rac.*, *Caust.*, *Asa-fæt.*, Bellad., *Mosch.*, Natr. mur., *Calc.*, Phos., Stram. ARSENIC, *Mephitis*, Sulp., *Hyosc.*, *Zinc.*

"*Tremulousness* : *Agaric.*, *Arg. nit.*, *Bellad.*, *Actea rac.*, *Cicuta*, *Ignatia*, *Stram.*, *Caust.*, *Zinc.*, *Lach.*, *Plat.*, etc.

"*Indurated uterus* : *Plat.*, *Alumen*, *Aurum*, *Sepia*, etc.

"In choreic movements, AGARICUS is distinguished by the spasms of the eyes and eyelids, spots here and there, which itch and burn. Redness of the inner canthi. This remedy is likewise of eminent use in irritation of the brain, with violent and rapid rolling of the head, increased bodily mobility, with twitching of muscles. Intellection diminished almost to imbecility. Here tarentula agrees and may be compared when friction caused by the rolling of the head on the pillow seems to give relief.

"STRAMONIUM is characterized by the following : Features continually changing ; now she laughs, now appears astonished ; tongue protruded rapidly ; head thrown backwards and forwards ; spasmodic twisting of the spine and whole body ; extremities in constant motion, though not always jerked ; for, sometimes their motion is rotatory, gyratory, even graceful. Muscles of the whole body in constant motion. Stammering. If the mind is affected

the patient is easily frightened ; awakes terrified ; assumes often an attitude of prayer, with fervent expression and clasped hands. Frequently lifts the head from the pillow.

"*Crocus* deserves mention because of the hysterical state it is capable of exciting, together with choreic symptoms. It causes jumping, dancing, laughing, desire to kiss everybody ; contractions of single groups of muscles. She is angry, and then suddenly repents ; or, angry and talkative, laughing, alternately. As in TARENTULA, music affects her. Hearing one sing, she begins involuntarily to join in ; but there is not the subsequent relief from music which is noticed in the spider poison.

"ACTEA RACEMOSA resembles the spiders in producing sleeplessness, restlessness and trembling ; fear of death ; and these evidences of nervousness are often, in the ACTEA, as in TARENTULA, reflex from uterine affections. The former has : after going to bed, jerking, commencing on the side on which she is lying, compelling change of position. Nervous shuddering, nervous chills. It has been employed in chorea of rheumatic origin, as well as of *uterine*. Mentally the two drugs differ. ACTEA causes nervousness, feels as if the top of the head would fly off ; delirium, with jumping from subject to subject ; sees strange objects. Great apprehensiveness, as a concomitant of uterine irritation. Pains darting into the eyeball, through to the occiput. Feels grieved, troubled, with sighing : next day, tremulous joy, mirth, and playfulness.

"*Hyoscyamus* is useful in well-marked local jerkings and twitchings of sets of muscles. The patient is sleepless and nervous ; or sobs and cries in sleep. The head falls from side to side. Talkativeness ; she laughs at everything in a silly manner. Stuttering. Mental excitement ; she is nervous, suspicious, troublesome but not maniacal.

"*Causticum* bears some resemblance in causing restless moving at night : she can find no quiet position. Intolerable uneasiness in the limbs in the evening. Anxiety and timidity in the evening. Trembling. Uneasy at night ; she awakes from a short sleep, anxious, scarcely allowing her to remain in one place ten minutes ; she was obliged to turn her head involuntarily from one side to the other, until exhausted, she fell asleep. During sleep many

motions with arms and legs. Jerks mostly of the right side of the body. Convulsive motions of mouth and eyes with sleeplessness and restlessness, after repelled eruptions.

"**BELLADONNA** produces bodily disquietude, indicating it in chorea. The patient is obliged to move to and fro, especially to move the hands and feet ; cannot stay long in any position. The predominant jerking is backwards, although this may alternate with a forward bending. There is boring of the head in the pillow, not mere rubbing it against the pillow as in **TARENTULA**. **BELLADONNA** has also constrictions, hyperæsthesia, mania with laughing, dancing, wild crying, etc. But it is distinguished by the intensity of its symptoms ; there are violent congestions, throbbing of the carotids, wild look, dilated pupils, and injected eyes.

"In hysterical states **IGNATIA**, though agreeing in many respects with **TARENTULA**, has a well-defined individuality of its own. The nervous system is over-impressionable, incoördinate in function and contradictory in action. The patient is extremely susceptible to emotional influences. Fear and grief affect her seriously ; the least contradiction offends ; she is readily chagrined, and so is often reduced to grief and tears by the slightest causes. Her mental states, however, are not usually exhibited in violence and rage. On the contrary, she nurses her troubles in seclusion and silence, and broods over them until they prey upon her whole system. She thus grows more and more nervous, and, at the same time, more and more weakened. The heart beats nervously, with variable pulse ; she frequently sighs heavily and deeply ; suffers from goneness at the stomach, with qualmishness and flat taste in the mouth ; feeling of a lump in the throat, swelling, sympathetically with the intensity of her mental disturbances. Sleeplessness or violent startings of the limbs. Grief, fright, disappointed love, or some other similar causes, may develop hysterical or choreic paroxysms. The moods change with wonderful rapidity ; now she laughs and jokes, when, quickly, she bursts into tears. Her manner becomes hurried, so that everything is performed hastily, and hence imperfectly and awkwardly. She is afflicted with intense headaches. These are characterized by a predominance of pressure ; the pain goes to the eye, which feels

as if pressed out ; or, to the root of the nose ; or again, it is confined to one small spot, like a nail pressing ; hence the name, *clavus hystericus*. At the height of the paroxysm, she becomes restless and chilly, and often describes a peculiar perversion of vision ; she sees fiery zigzags when looking out of the line of vision (see *Theridion*). Finally a profuse flow of colorless urine terminates the attack.

"While, then, both remedies induce sadness, indifference, profound melancholy hysterical states, only *IGNATIA* has the introverted state of mind ; only *TARENTULA* the cunning attempts to feign paroxysms, and wild dancing.

"*Platina* should not be confounded with the spider-poisons here, because it develops a different form of hysteria. True, there are present deranged coördination of functions, anxiety, trembling, fear of death, which seems to the patient to be imminent ; also, alternation of depression with gayety and laughter ; sexual excitement ; convulsions. But the patient assumes a hauteur, a self-exaltation, which is foreign to the other drugs considered. Her mental disturbances develop into a condition of self-esteem during which she looks disdainfully down on all around her. Her paroxysms of laughter are not only loud and boisterous, but ill-timed, coming on even under circumstances of a sad nature. The headaches are of constrictive character, as in *TARENTULA* ; but there is, in addition, a squeezing, cramplike pain, with numbness, and the pains gradually increase and as gradually decrease.

"Indurated uterus belongs to the symptoms of both.

"*Palladium* is readily distinguished by its unique mental phenomena. The patient is not haughty, but she is irritable, and is, unfortunately, given to strong and violent language. Music, society, or animated conversation excites her, and produces pains in the right ovary ; the following day she feels correspondingly used up. Her egotism is displayed in a fondness for the good opinion of others, hence she is continually getting 'slighted'. The uterine symptoms are characterized by a weakness, as if the womb were sinking ; empty feeling in the groins, as if eviscerated."

## CLINICAL OBSERVATIONS BASED ON OVER FOUR HUNDRED ABDOMINAL SECTIONS.

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BY

R. LUDLAM, M.D.,  
CHICAGO.

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(Continued from page 425.)

4. *The incidental vomiting.*—Experience has taught me that very much can be done to avert the chloroform vomiting which is so distressing and sometimes so mischievous in peritoneal surgery. If the diet of the patient is carefully regulated and hard, indigestible food is not allowed for some days before the operation; if the bowels have been thoroughly emptied by a saline purgative, and the rectum cleansed by enemata; and if the patient is not allowed to take more than a cup of tea, or of bouillon, on the morning of the operation, much will have been done by way of prevention. But the rule must be hard and fast and it must be implicitly obeyed.

Another prophylactic of this form of vomiting is to have the patient placed upon the table before the anæsthetic is taken. To give it to her while in her room, and in her bed, and then to carry her to the operating table will almost certainly induce emesis; and, although our private patients sometimes object to this method, a sensible explanation will satisfy them and gain their consent.

In the early days I always had the patient take a big drink of whisky, but of late years a hypodermic of brandy, whisky, or of morphine and atropia was given before the operation, the theory being that it would prevent shock, secure immunity from pain for some time afterward, and lessen the tendency to vomiting. Now, however, it is a very exceptional case if I use morphia at any time, and the whisky (old rye) is reserved for the after-treatment. I

believe that given occasionally, not by the mouth, but hypodermically, during the first twelve or twenty hours, especially if the operation has been prolonged or the patient is very weak and the stomach very irritable, whisky will often prove of the greatest benefit. Those women who have been accustomed to depend upon almost any kind of stimulant, including morphine and the bromides, ought not to be deprived of whisky under these circumstances. It certainly lessens the risk of vomiting by acting as an antidote to the anæsthetic, thus helping the patient to be rid of it sooner than could otherwise happen.

Incidentally a hypodermic of whisky is not only of direct benefit as already stated, but it often serves to put the patient to sleep, under the impression that she is taking an anodyne, and thus spares her the disagreeable after-effects of morphine and kindred drugs.

I am satisfied that in certain weak and impressible subjects there is less likely to be trouble with the stomach if there is no "suggestion" of nausea and of the sickening effects that usually follow the taking of an anæsthetic. And so of late my rule is to forbid the nurse, or the doctor, to say anything in the hearing of the patient that would remind her of the possibility of such a symptom. For, small and trifling as this matter may seem, "prevention is better than cure," and we must keep all the sources of mischief out of the way.

Since the barbarous old clamp has fallen into disuse, the suffering that followed an ovariectomy is very much lessened, and so also is the liability to immediate and obstinate vomiting, strangury, cystitis, and the necessity for using the catheter.

Certain cases of auto-infection, in which the vile fluids from old cysts have been taken into the circulation before an operation was attempted, are accompanied by the most obstinate vomiting. I have learned to look with suspicion upon a case that comes to me with an aphthous condition

of the mouth, a very irritable stomach, partial urinary suppression, and occasional attacks of an exhausting diarrhoea, for these symptoms are almost certain to depend upon a pre-operative sepsis with ulceration of the gastro-alimentary mucous membrane. In a patient who was brought to me by Dr. C. W. Eaton, of Des Moines, Ia., in November, 1880, and upon whom I operated in the hospital, these symptoms were very prominent. The tumor weighed twenty-five pounds, was multilocular, the largest cyst being crowded into the epigastric region. Despite the most vigilant nursing and care, the vomiting increased, and she died of confirmed sepsis on the morning of the fifth day. A careful autopsy showed that the wound had healed very kindly and completely, both internally and externally. There were no signs of peritonitis anywhere, no effusion of blood or of lymph, no clots, and not a drop of pus could be found along the incision or about the pedicle or the clamp. In all respects the process of union and of repair had proceeded without any arrest or complication. But the stomach was greatly dilated and contained three pints of a dirty ochre-colored water.

On being opened along its greater curvature, nearly one half of its mucous surface was found to be highly congested and in a state of violent inflammation. Near its middle portion and along the larger curvature were three distinct ulcers, the largest of which was nearly as big as a dime. These were in the midst of the inflamed area, and were evidently acute and active in character, being partially covered with pus. On either side of these recent ulcers was a row of dark-colored spots which the physidians present recognized as so many cicatrices of ulcers that must have healed. They had the appearance of shot-holes, and there were more than twenty of them. I have had two other cases with the same symptoms before death, and similar lesions at post-mortem.

In a communication which I had the honor to make to



this Society in June, 1785,\* this complication was thoroughly discussed, and its clinical significance established.

In a few cases where the vomiting has been unusually persistent, continuing for thirty hours or more from the time of the operation, and accompanied by great restlessness and a rise of temperature, without any corresponding signs of sepsis, I have found the trouble to depend upon iodoform poisoning. This condition has been recognized by the peculiar color of the urine, and by the appearance of the black line in the test tube when strong nitric acid is added to that fluid. In a hospital case in which I made a tubo-ovariotomy in May last upon a patient of Dr. C. A. Weirick, of Mar-seilles, Ill., the vomiting continued into the second night, and without any assignable cause; at 2 P.M., the temperature mounted to 102°, where it remained without variation until I saw her at nine o'clock in the morning. The urine was found to be extremely yellow, and the nitric acid test detected the iodine without doubt. I ordered the dressings removed from the wound, the iodoform to be dusted off, and the iodoform gauze exchanged for the mercurial gauze. In two hours the vomiting had ceased and the temperature had fallen two degrees, after which the patient made an un-interrupted recovery.†

It is not rare to find those to whom the smell of iodoform is so disagreeable that it will make them ill if it is used for dressing the abdominal wound. One way of obviating this result, while we preserve the good effect of this agent for destroying the ptomaines, is to use Terrillon's mixture of iodoform and vaseline, which can be smeared over the wound and then covered directly with absorbent cotton. But, in case it is so objectionable, it is better to omit it

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\* See "A Peculiar Cause of Fatality after Ovariectomy," the *Clinique*, vol. vii., page 268; and also Helmuth's *Surgery*, 5th edition, 1887, page 1091.

† For further information on this subject see an excellent paper entitled "Iodoform Poisoning; a good test for Iodine in the Urine," by E. M. Bruce, Analytic Chemist, in the *Clinique*, vol. xi., page 296.

altogether, and either to substitute something less<sup>o</sup>offensive, or to depend upon absolute cleanliness and the complete protection of the wound from the admission of air.

5. *The choice of time for making an abdominal section.*—

Unless in some great emergency, it is best to select the time as well as the place of operating with considerable care. Most of my sections have been made at mid-day, when the light was the strongest. I have seldom opened the abdomen when the weather was stormy and the wind in the east, and when I have been forced to do so my patients have not done very well. The theologians have not told us whether what is said in the Bible about "filling the belly with the east wind" applies to these cases; but it seems certain that such conditions sometimes have a very depressing effect upon the patient, and militate against her recovery. Fortunately, in the latitude of Chicago it is quite exceptional to have the wind from that quarter, and, therefore, our work does not often require to be postponed for that reason.

In making an ovariectomy, or a supra-vaginal hysterectomy, the season and the outside temperature are not regarded as they were a few years ago. At first we never operated in July or August, and seldom in the extreme winter weather. But now, in serious cases in which delay is dangerous, we go forward, taking care to counteract the untoward conditions as best we may. In July last (1890) I removed an extra-uterine fibroid from a patient of Dr. G. W. Munroe, at Blair, Neb., the outdoor temperature being 108°. She made a good recovery. Of ten ovariectomies that I have made in Minnesota when the thermometer ranged from 6 to 36° below zero, every one got well. February 2, 1878, I removed an ovarian tumor weighing eighty pounds, the cyst-wall being extremely adherent to the parietes and so vascular that it was split until we got beyond the line of union, and then cut through, all around, and the tumor taken away. The operation had been deferred

two days because of a severe snow-storm; but now the air was crisp and very clear, and the temperature twelve degrees below zero. She, too, made a good recovery. So that, while we cannot fence out the east wind, my experience confirms the idea that it is possible to protect these patients against harm from the extremes of heat and cold, if we go about it properly.

On reaching a flourishing little town in Nebraska, in April, 1888, for the purpose of making an ovariectomy, the physician who met me at the railway station expressed his fear that I would not operate, and his opinion that, after all, we would be obliged to wait a week or more because his patient had just begun to menstruate. I replied that if she were well enough in other particulars, it would make no essential difference, but, in truth, I had never before entered upon this operation under similar circumstances. We did wait over the next day, which was Sunday, because it was rainy and nasty; but on Monday the tumor was taken out, while she was still flowing. No injurious consequences followed, and she recovered promptly.

Since that time, while I would prefer to make an ovariectomy a little before or soon after the menstrual period, I have not hesitated in severe cases to disregard the fact that the patient might be flowing at the time. In the case of bleeding fibromata that must be removed through an abdominal section, I very much prefer to operate just before the monthly discharge is due, for then the patient is at her best degree of strength, and whatever blood is saved will help her to react and recover. And the same remark applies to the Battey-Tait operation when it is made for the purpose of putting an end to the dangerous and uncontrollable menorrhagia that sometimes attends upon uterine fibromata.

But my experience has led me to conclude that, when a tubo-ovariectomy is undertaken for the cure of dysmenorrhœa from salpingitis, and from structural disease with or without enlargement of the ovaries, the most suitable time

for operation is soon after the flow. For, if it is made immediately in advance of period, and you should think best to remove but one ovary and tube, the struggle to establish the discharge through or by the remaining appendages might easily add to the risks of the early convalescence. This would be especially true if, as usually happens in confirmed cases, the patient has been subject to a relapsing peritonitis on slight provocation. All causes and signs of sepsis apart, several of my patients, upon whom I operated just when the menses were due, have shown the ill effects of my choice of time for doing this work. Indeed, unless it is to anticipate and to avert a menstrual hæmorrhage, even where both of the ovaries and tubes are taken, it is best whenever we can do so to avoid the shock and the crisis that are incident to the monthly molimen. And this can be done by choosing a point of time midway between two periods.

The highly neurotic condition that attends upon an immediate post-operative return of the monthly cycle, whether the menses come on or not, is sometimes shown by the clinical thermometer. Where the appendages have been removed from both sides, and the flow is practically impossible, we may have such a rise of temperature and such a perturbation, possibly with abdominal distention and vomiting, as will lead one to fear the advent of a septic fever or inflammation. The same is true of the recurrence of the period directly following a hysterectomy, whether that operation is partial or complete, and whether it has been made by the abdominal or the vaginal method. In one of my cases of vaginal extirpation of the uterus already reported to this Society, the patient's temperature suddenly rose on the fifth day to  $109^{\circ}$ . It came down almost as suddenly, and she recovered without an untoward symptom. In one of my hospital cases, where the right ovary and tube were removed for a frightful dysmenorrhœa with hystero-epilepsy, the return of the period on the second day sent the tempera-

ture to  $105^{\circ}$ ; she became very nervous and restless, and threatened to have the usual fit, but did not make it out, and finally got well again without any recurrence of the old difficulty. Indeed, now that six months have passed, she menstruates almost without pain and has no more of those "horrid" spasms.

That peritonitis with its unwelcome train of symptoms is more likely to occur under these circumstances than it would be if we were careful to remove the uterine appendages, or even the uterus itself, after instead of before the flow, has been made evident to my mind by a number of cases which need not be detailed in this connection. Suffice it to say that during the last eighteen months I have been more careful in this regard and with much better results.

*(To be continued.)*

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## FŒTUS PAPYRACEUS.\*

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BY

E. LIPPINCOTT, M.D.,  
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In January, 1882, I was hurriedly called to see Mrs. McN——, and found her with a free, intermitting hæmorrhage and pains, showing a decided tendency to miscarriage, as a result of a fall a day or two after having first felt foetal movement.

With considerable effort and time a miscarriage was prevented. Again in January, twice in March, and again in May, I was called on the same mission, finding my patient in nearly the same condition each time as on my first call. The result will demonstrate that this was a missed miscar-

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\* A paper read before the Homœopathic Medical Society of Tennessee, in annual session on Lookout Mountain, Tenn., September 10, 1890.

riage. On the morning of June 5, 1882, I was called to attend her in labor, and found her sitting in a chair by a window, without yet having had a single pain. The usual questions elicited nothing unusual, other than that she had never had more than three pains at any confinement except the first. After waiting a half hour or more, and no pains or other objective signs of labor, I decided to return to my office near by, during office hours, and have them call me when needed. The patient objected to my going, saying that she knew it would not be long before she would need me, and that they would not have time to send for me then. Inside of another half hour the first pain came on, and we barely had time to get her on the already prepared bed when two pains followed in quick succession and a child was born.

As the abdomen seemed too large and tense, the uterus too large, and the patient not needing my services, I waited for pains to deliver what I supposed was another child, while I gave attention to No. 1. After attending to this child, and finding the mother comfortable and without having had any pains, I proceeded to examine her to account for her size, and finally made a digital examination and decided to deliver the placenta, which, to my astonishment, was an unusually large one. Two cords were found, four and three-quarter inches apart at their attachment, and to one of them an amniotic sac, perfectly intact, containing a dead foetus, with a small quantity of caseous matter, but no fluid, and the foetus very much flattened.

It seemed to have died in utero at or about four and a half months, judging from its size and the history of the case. The portion of the placenta to which the cord of the dead foetus was attached had been torn loose from the uterine wall (doubtless at the time of the fall), had become thickened, and undergone fatty degeneration.

This case is what is called *Foetus Papyraceus* by J. Matthews Duncan, M.D., etc., in his "Clinical Lectures on the Diseases of Women," 1880, page 10.

ON THE FUNCTIONS AND LESIONS OF THE  
FALLOPIAN TUBES, IN THE LIGHT OF MOD-  
ERN GYNÆCOLOGY.\*

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BY

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The history of the development of every department of natural knowlege is that of the continual exuviation of old conceptions and the continued assimilation of new ones. Two rules of procedure the scientific mind keeps ever before it ; the first, that every observation shall be capable of continual verification ; the second, that every interpretation of natural phenomena shall be altered, expanded, or abandoned, when required by wider knowledge and newer discovery.

The scientific basis of the art of gynæcology is in this latter transitional condition ; and to the wider conceptions and the exacter knowledge of recent times I wish to call your attention to-night. But as with a time-limit must be a space-limit also, the special facts and connoted ideas for our consideration will be those associated with the tubes of Fallopius.

Now in no department of gynæcology has recent research been more fruitful, and recent observation more revolutionary, than in the sphere of the fallopian tubes. Ten short years ago they seemed the most insignificant elements in the pelvic mechanism ; to-day, the facts relative to them rival in extent and importance those appertaining to the ovary itself. At the commencement of this decade, not a text-book but passed them over as unimportant or meaningless ; and no voice was heard calling attention to the

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\* Read before the British Homœopathic Society, June 25, 1890.

new epoch at hand. Old gynæcology was fast passing into a *reductio ad absurdum*. Wedded to old instruments and old ideas, it had overlooked lacerations of the cervix, and called every glandular hypertrophy or ectropion an ulcer; it relied for its diagnostic skill on that doubtful instrument the sound, and thought the part of the uterus showed by the speculum to be all that demanded attention; it tapped ovarian cysts, and maimed its hundreds with stem-pessaries. But the epoch-making forces were at hand; and these undoubtedly were the success of abdominal sections, specially in their remote issues; and the perfection of that method of precision, the bimanual. To the former we owe what knowledge we possess of the functions and curable lesions of the tubes; from the latter we derive our exact diagnostic knowledge of the nature and relations of foreign masses in the pelvis. Take away all the facts revealed by these two modern methods, and our usefulness is crippled and our resources barren. To the last decade, then, I give the title of "progressive epoch"; and what it has done for us in the closer knowledge of the fallopian tubes I must now recount.

We are all familiar with the embryonic stages of growth of these uterine appendages. From the Müllerian ducts and the Wolffian bodies the generative apparatus of later life is chiefly derived; but from the Müllerian ducts alone the uterus and fallopian tubes are developed. By the eighth week of embryonic life, the Müllerian ducts appear as two tubular processes, adjacent but distinct from each other. At the end of the twelfth week the opposed lower segments of these tubes have fused, so as to form a single tube below, a double tube above. The twentieth week shows a decided differentiation into fallopian tubes above, and uterus and vagina below. From this time to the termination of foetal existence, the tubes gradually assume a rectangular relation to the uterine axis, the corpus uteri becomes well marked, and, finally, in the angle of union,



the deposition of tissue forms the thick vault of the fundus uteri. The development of the genital canal is now complete.

Abnormalities may arise from the arrested development of any part of the evolving genital tube (lower, middle, or upper third), or from the non-absorption of the septum between the tubes, in whole or in part.

## II.—STRUCTURE OF THE TUBES OF FALLOPIUS.

Of prime importance is it to remember that the fallopian tubes are only partially surrounded by peritoneum; this fact is essential to know in tracing the natural history of some ectopic gestations and hæmatoceles. Slung in a meso-salpinx, one aspect of the tube is directly related to the connective tissue of the broad ligament; while its outer and free extremity is possessed of a moderate range of mobility, permitting its adhesion to other viscera, its dislocation in tubal lesion, and its close application to the ovary as the climax of a series of muscular movements at the time of the period.

Of the three tubal tissue-tunics, the inner is the only one possessing characters for remark. The outer one is the usual peritoneal investment; the middle, a mass of non-stripped muscular fiber, arranged in a thick circular and a thin longitudinal layer; but with the inner lining centers the chief interest of the tube. In this epithelial sheet are conjoined several extraordinary anatomical anomalies. Although freely secreting mucus, glands are entirely wanting in it; and the usual goblet or chalice cells are conspicuously absent. Its surface is thrown into a highly complex system of plications and reduplications, whose function is only to be explained on the theory of increase of secreting surface. And the superficial cell layer of this secreting membrane is continuously ciliated, until the free end of the tube is reached, when the epithelium suddenly becomes squamous, and the tubal lumen debouches into the serous cavity.

Much controversy has raged round the question of glands or no glands in the tubes of Fallopius. Because its contents were found to be mucous, therefore it ought to have glands; if it ought to have them, they must therefore exist. But the most assiduous histological hunt failed to disclose more than a favorable appearance here and there which might fairly be construed as glandular. Bland Sutton in England, and Henning in Germany, have taken the question up, but seeking for glands where none existed have left the matter much as they found it. Speaking of this topic, that most distinguished of Vienna histologists, Prof. Weichselbaum, declared to the writer that prolonged observation had entirely failed to disclose glandular structures in the tubes. And the gynæcologist at the Poliklinik, Prof. Lott, plainly declared that the whole epithelial lining of the tube was a secreting sheet, and in this view of Lott's we entirely coincide.

Now, the unification of these conflicting views is easily effected, and the cause of the mental confusion is a very interesting instance of Bacon's *idola tribus*.

The idea of glands, as such, in the tubes is an entirely foreign and imported one, not derived from observation, but from analogy with other secreting structures in the body. What is the necessary antecedent of mucous secretion? Obviously, cells specialized for such function: the arrangement of secreting cells in pockets (glands) bearing no necessary relation to the function of secretion, but bearing a very distinct relation to the extension of surface requisite for the massing of secreting cells in sufficient number. How are the secreting elements in mucous membranes usually placed? They are stored away in crypts, glands, or pockets, partly for protection, partly to reduce the surface area of membrane to a workable minimum. How are secreting cells arranged in the fallopian tubes? Here no protection from transmitted contents is necessary, and the requisite extension of surface area is obtained by the device of plicæ.

What glandular crypts are to ordinary mucous membranes, plicæ are to the fallopian tubes, and the diagnostic criterion of secreting cells, packed in a tract of squamous epithelium, is that they differ in epithelial type from those cells that merely line. The cells in the fallopian tubes in and out of plicæ are perfectly homogeneous in character, and no differentiation into lining and secreting elements is here found.

### III.—FUNCTIONS OF THE FALLOPIAN TUBES.

Until quite recently, our knowledge of tubal functions was scant; and had the further character of being nearly entirely erroneous. Before abdominal sections, with their opportunity for observation on the human female, took the place of vivisections and other investigations on animals, our conjectures as to the functions of these ducts were entirely deduced from facts derived from the lower animals in a feral or a mutilated state. For human female, read dog, or cow, or pig, and the observations stand on their own basis; but here as elsewhere, the bold reading of similar functions from structures that only resemble, and in conditions that are not even similar, has been prohibitive to progress.

The institution of fallopian tubes as oviducts to a uterus begins only in mammalia. The fusion of the Müllerian elements to form single uterus and single vagina is quite a late feature in comparative embryology. A break in continuity is established between ovary and oviduct; a single uterus is present, and the fallopian tubes, bent at a right angle to the uterus, are only in occasional contact with the ovary. These facts seem to be mainly relative to the erect posture, and further to limit the prolific character of female organisms so notable lower in the scale.

At the time of the period, the fallopian tubes undergo such muscular movements as eventuate in their application to about a third of the surface of the corresponding ovary. The fimbriæ are spread out and turgid with blood, and the contact is thus very exact. This has actually been

seen in the living human subject. The ovary may not have a follicle sufficiently ripe to burst and discharge its ovum; or the tube may not grasp the ovarian area where such follicle exists. Both these facts also have been observed in the living human subject.

Should an ovum be successfully dehiscent into the tubal lumen, the cilia of the epithelium propel it down the tube into the uterine cavity. How long this takes we do not know; and conjectures as to the exact period are not founded on sufficiently precise evidence to be accepted. The same direction of motion of the cilia propelling the ovum, also is said to tend to prevent the access of sperm elements into the tube. Probably this is so. The muscular elements of the tube can take but little part in the propulsion of the ovum; for a very little consideration of the complex foliation of the tubal lining will show this to be impossible. Obviously, if the ciliary mechanism in whole or in part be destroyed by disease, the ovum remains in situ, the ingress of sperm elements is not obstructed, fertilization takes place in the tube, and a tubal pregnancy with all its lethal issues results. To complete the picture, in tubes sealed by adhesion or impacted by inflammation, no conception occurs, for no ovum is transmitted.

Does this sketch environ the functions of the fallopian tubes? Until the last few years, the reply would have been yes; but recent progressive work has revealed an area of influence not yet fully worked out, of quite as extensive and important a nature as oval propulsion.

The common but quite erroneous assumption has been that the ovaries initiate and condition menstruation. The work of recent years has incontestably proved that the ovaries have little or nothing to do with menstruation; that this function is solely and wholly that of the uterus and tubes. To discuss this question would require more limits than time can afford, and I must perforce content myself

by making the following serial statements ; each and all of which are legitimate deductions from observed facts :

1. Menstruation has no analogue in the lower animals, and no similar function exists even in the higher apes ; it is essentially the outcome of textural conditions strictly relative to the erect posture, and becomes accentuated as civilization advances.

2. The periodicity of menstruation bears not the least necessary relation to the periodicity of ovular dehiscence ; and, being rhythmic, is probably ganglionic in origin ; bearing some relation to the time-limit of existence of the exuviated uterine material.

3. Entire destruction of the ovaries by disease, or complete removal by operation, in many cases has not the slightest influence on the regular performance of the menstrual function.

4. Entire removal of the tubes alone permanently arrests menstruation in ninety per cent. of operation cases ; lesion of the tubes very frequently causes increased menstrual flow.

5. The maturation and rupture of ova from Graafian follicles goes on before puberty, in cases of primary or secondary amenorrhœa, and during lactation ; that is, in cases where menstruation has never been established or has become suppressed.

6. Menstruation commences in the tubes ; is most profoundly affected by removal of this starting point ; but certainly is not caused by tubal presence.

To summarize, all we can say is that removal of the ovaries alone has little influence on menstruation, that removal of the tubes alone has a very considerable influence on menstruation, and that in some cases removal of ovaries, tubes, and great part of the uterus itself does not arrest the regular performance of this periodic function. This proven occasional independence of organic integrity, and its rhythmic character, tend to turn our investigation to the nervous

centers for its initial impetus; and if one may forecast, it is possible that like the vaso-motor filaments round an artery regulating its functions, there are nervous plexuses in and around the tubes and ovaries and uterus, conditioning the monthly flow; but that the uterine and tubal filaments and centers have a preponderating influence over the ovarian ones in relation to the performance of menstruation.

*(To be continued.)*

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## LACERATION OF THE CERVIX UTERI.

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BY THE LATE  
F. S. FULTON, M.D.

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*(Continued from page 362.)*

It is to assist in obtaining the proper degree of tension of sutures that the shield is useful. After the wires are properly drawn together by the fingers with sufficient force to hold the lips in easy coaptation, and given a half turn to hold them at that point, the shield is pushed down upon the cervix and the wire bent over that at a rather sharp angle. If the wire is good there will be no twisting beyond the angle formed by its bending over the shield, even though it be twisted very tightly up to the instrument. In fact it will break before tightening beyond this point. It is safer to leave them apparently too loose than too tight, because there will always be more or less inflammatory swelling, which will easily fill out any gap but which will cause sloughing if the sutures be tight. The sloughing will not be serious, merely the tissue around the stitches will be eaten into. Usually it will not seriously affect the ultimate result of the operation, but even this amount of sloughing is unnecessary if sufficient care is exercised in not drawing

them too tight. After being twisted, the wire should be bent over a tenaculum toward the cervical canal and cut off, leaving about half or three-quarters of an inch which can be grasped when the sutures are removed. Many operators prefer to bend the wire directly backward over the posterior lip and then cut them away; but I prefer to place them parallel to the line of position of the two lips, for the reasons that not the slightest inconvenience has ever been experienced from the wires which have been so treated; and as the uterus should be well anteverted after the operation, if the sutures are turned back over the posterior lip, the ends are brought more directly in contact with the posterior vaginal wall, and when they are removed they are exactly where you don't want them, and if, as is usually the case, the uterus is high up, it affords additional difficulty in their removal. Besides, if the sutures are turned in toward the center from both sides it is more easy to find the wires leading to the outside sutures, which, unless this expedient is employed, at times become buried in the folds of membrane and greatly delay the removal.

Another point about the insertion of stitches, which will apply as well to other parts of the body as to the cervix, is, do not insert too many. The fewer inserted which will hold the tissue in good apposition, the better. I believe that three on a side is all that is needed for the most extensive laceration of the cervix, and for moderate ones two is better. The most perfect union I ever had or saw was in a case in which three sutures were used on one side and two on the other; and twisted much looser than it is usually the custom. When the stitches were removed entire union had resulted, and there was not a break in the continuity of the mucous membrane covering the cervix, except where the sutures entered and found exit. The teaching of many operators is to insert all the sutures possible, and the more that can be introduced the better will be the union. The results of a large number of operations in which this method

has been followed has led me to an exactly opposite conclusion. More stitches than are absolutely needed to hold the parts in apposition, and that is comparatively few, tend to strangulate the tissue, especially in weak, anæmic individuals, and to prevent union by sloughing under the sutures. Not only that, but it unnecessarily prolongs the operation, which is a very grave error. One great factor in the success of Dr. Tait's ovariectomies is the rapidity with which he operates, and the very short time in which his patients are kept under the influence of an anæsthetic. In a lesser degree, the same principle holds true in operations on the cervix or elsewhere. *Cæteris paribus*, the less the shock and the more rapid and easy the convalescence of the patient.

All the sutures are treated in the same manner. In the introduction of the needles, when the cleft is very deep there is sometimes great difficulty experienced in bringing the needle out in the desired point in the angle of the cleft, it being difficult to reach the exact bottom without going deeper than necessary. To overcome this difficulty, the needle can be inserted in the inmost portion of the cleft, which has been previously hooked up with a tenaculum, and passed through the lips from within outward and the needle unthreaded. The loop is carried out with the needle, leaving the detached ends in the angle of the cleft. A second needle is inserted at the same point as the former and carried from within outward through the opposite flap. In this case the detached ends are carried with the needle, leaving the loop in the angle. Through this loop the detached ends of the first thread are passed and drawn through the second flap, thus drawing the first thread through both lips and insuring its reaching easily the deepest angles of the laceration. The wire or whale tendon is then to be hooked into this and drawn through. The wires being all in position, a sound is introduced into the cavity of the uterus to ascertain if the canal is pervious,



the uterus replaced in position and rather strongly anti-verted, a final douche of merc. bich. given, or, if any oozing is observed, of very hot water, which will usually contract it without trouble, the patient cleaned up by the nurse and removed to her room and bed.

*After Treatment.*—In ordinary cases this is exceedingly simple. No medicines are necessary unless fever or soreness from the stretching of the ligaments in drawing down the uterus manifest themselves. If fever appears, aconite tinct. will usually control it, while rhus.\* acts best in relieving the hypogastric soreness and tenderness. Cloths wrung out in hot water and applied after the manner given below will add materially in relieving the discomfort. Probably for the first day or two, especially if the bichloride solution has been used, there will be a slightly bloody, serous discharge. This is of no consequence, even if it should continue for some time, and needs no especial attention. Douches need not be given unless the discharge becomes purulent and offensive. In fact, it is better here, as in all surgical procedures, to allow nature to be her own nurse as far as possible, and not to needlessly interfere with her processes of repair, for which she is usually amply sufficient, by unnecessary douching and assistance. If, however, the discharge becomes purulent and offensive, douches of warm water, to which may be added a little carbolic acid, about 1-100, or boracic acid, are to be given as soon as the vaginal discharge appears. These may be given two or three times a day. If the patient can pass her urine she may be allowed to do so, receiving a slight douche of warm water immediately after each urination to avoid any urine getting upon the parts. If, as is sometimes the case, she is unable to void the urine herself, the catheter must be used every six or eight hours according to her individual requirements.

The patient should be kept in bed until after the stitches are removed. She need not be limited as to position, but can

occupy any which is most comfortable. It is best for the patient to avoid any great restlessness, as it may irritate the parts. It is rare for any secondary hæmorrhage which will need attention to occur, though Dr. Mundé in the *American Journal of Obstetrics* for October, 1883, reports three cases in which quite violent hæmorrhage occurred on the fifth and sixth days respectively. Dr. Emmet also, I believe, records a similar case. If such occurs the hæmorrhage can be controlled by ample douches of hot water, or rather strong alum water; or a little water to which has been added enough iodine to rather strongly color it can be thrown into the vagina and retained for a time, or by painting the cervix with Churchill's iodine, and if these fail, a tampon moistened with glycerine and covered, on the part which will lie against the cervix, with powdered alum, or a vaginal suppository containing twenty grains of powdered alum and enough cocoa butter to hold it well and make a good sized suppository, can be inserted.

If the hæmorrhage is not checked by any of these means, the patient may be placed as Dr. Donaldson has suggested, upon the table, or bed, if necessary, the speculum inserted, the cervix drawn down, steadied with the counter pressure hook, and a large needle, threaded with heavy silk, driven through the center of the cervical canal; the thread is then caught on a tenaculum in the canal, drawn out and cut, leaving a thread passed through either lip, deep in its substance. By tightening these threads alternately it can easily be seen which one controls the hæmorrhage, as one will probably do. A perforated shot is then slipped down close to the cervix, traction made upon the silk, the shot clamped down upon it, and the whole allowed to remain. The thread in the opposite lip is then removed. The shot ligature is allowed to remain in for twenty-four or forty-eight hours, when it can be removed with little danger of a recurrence of the hæmorrhage. Some of these methods will no doubt control the bleeding. It is not usual for the

patient to experience much pain after trachelorrhaphy unless great traction has been exerted in drawing the uterus down at the time of the operation, or unless there exists severe pelvic inflammation which has not been removed by treatment, thus inciting a fresh attack of cellulitis or peritonitis. If these unfortunate complications arise, they must be treated according to their special indications. In addition to such remedies as ac., bell., bry., as., carb. veg., kali chlor., kreos., arn., apis, and others, which find their legitimate sphere of action in this morbid condition, great relief and benefit will be derived from the abundant use of hot water applied as a vaginal douche and also as hot fomentations. The douches, to be effective, must be given early, and in quantities of not less than a gallon, three or four times a day, while the fomentations must be applied by soaking four thicknesses of flannel in as hot water as can be borne and applying them to the abdomen. Over this is placed a piece of oiled silk or rubber tissue and the whole covered with four thicknesses of dry, hot flannel. This must be changed as often as it becomes cold—every two or three hours will generally suffice. If a rubber coil can be had, and be made to work so as not to suddenly burst and scald the patient, it will do excellent service.

On the seventh or eight day, if the patient has progressed favorably, the stitches are to be removed. If perineorrhaphy has been performed at the same time as the trachelorrhaphy, the stitches in the perineum had best be left till about the tenth day, while those in the cervix should remain a month longer. No harm will accrue from the presence of the stitches in the cervix. Dr. Hunter, of New York, reports that in frequent cases he has allowed them to remain for from one to two months with no harm arising. If whale tendon or cat-gut has been used, of course it obviates the necessity of removal.

Ordinarily the removal of the stitches is not painful. The twisted end of wire is grasped by long dressing forceps,

and cut by a wire cutter, or wire scissors which have a short arm on the end of the blade, at right angles to the long diameter, to hook up the wire. The cervix is then steadied and the wire drawn out over the line of union, not away from it. This prevents any traction being made upon the newly united surfaces. Each wire is then removed. Care must be taken not to cut the twisted portion of the wire close to the suture. If this accident happens, and it is not difficult to make this mistake, it is very hard to find the suture, as it will be imbedded somewhat in the tissue. It is better not to irritate the parts too much by searching for it, but allow it to remain till the cervix has somewhat reduced in size, when it can be detected more easily. After the removal of the stitches the patient should be confined to her bed for two or three days, commencing to sit up and walk on the eleventh or twelfth day.

If, on attempting to remove the wire, the operator finds, much to his chagrin and disappointment, that the surfaces have not united, or, still worse, have sloughed, he must irritate the surfaces with scalpel, probe, scissors, or anything which will freshen the indolent parts, tighten the wires a little, if need be, and leave it alone for another week. Not infrequently a second examination will show very fair union. If, after all, union fails to result, the wires must be removed and the parts healed by the *argentum nitricum* solution. For this purpose a solution containing from twenty to forty grains to the ounce will be needed, according to the depth of the slough and the sluggishness of the parts. Dr. Emmet reports a case in which sloughing and consequent non-union followed two successive operations, upon the same individual, which was subsequently healed by *arg. nit.* The benefit to be derived from the operation is not always to be measured by the perfection of the union following. If the cicatricial plug has been removed from the angles of the laceration the same good results will generally accrue, even if union does not follow. By clean-

liness and stimulating applications, as arg. nit. or iodine, the gap will usually fill up, the irregularities resulting from the projecting lips be smoothed down by absorption, and the cervix ultimately present a very creditable appearance. If it is healed without the development of cicatricial tissue, the same good results will accrue. If erosions spring up, and the lips evert, the condition of hyperplasia with attendant neuroses will return and greatly impair the result of the operation. In this case a second operation is all that promises any favorable result.

The benefits of trachelorrhaphy do not always immediately follow the operation. In certain cases, even of long standing, the tormenting headache or backache will disappear as by magic as soon as the patient recovers from the influence of the anæsthetic, and she will obtain the most refreshing and enjoyable night's sleep which has visited her for years. As a rule, however, there is a very gradual improvement which must be measured by months. And it is not unusual for a year and a half or two years to elapse before the patient realizes the full benefit of her operation. She should be acquainted with this fact in order to guard her from yielding to disappointment when the expected beneficial results do not at once appear, and also to prevent her attaching blame to the surgeon for subjecting her to an operation from which she sees no present benefits. Not infrequently, as a result of the mental excitement of the operation and the mechanical irritation of the parts, menstruation will appear. This ordinarily causes no disturbance, nor does it appear to retard the healing process. If the discharge from the wound is slight the douches can be omitted during the catamenial flow.

The mortality after trachelorrhaphy is very low. Dr. Mundé reports one case in which the patient died of septic peritonitis, though the wound healed perfectly. A few other cases are also recorded. Ordinarily, however, it is an operation remarkably exempt from surgical dangers. Sta-

tistics show that failure of the denuded surfaces to unite occurs in about eight per cent. of cases. This lack of success may be occasioned by sloughing, appearance and long continuance of the menstrual flow, the too speedy getting up of the patient, or by lack of proper preparatory treatment, thus operating before the congestion, subinvolution, cystic degeneration, erosions have been removed.

*After Results.*—The length of this chapter will allow of but a word regarding the effects of trachelorrhaphy upon sterility, subjective and objective symptoms, the pathological condition attributable to the lesion, and the tendency to laceration in subsequent deliveries. The uterus gradually returns to its normal size, the subinvolution and hyperplasia disappear, the cervix assumes its natural conicity, and becomes covered with a healthy, pink mucous membrane. The endometritis and consequent leucorrhœa usually subside in from a few weeks to several months, and the menstrual flow becomes more free from pain and again approaches the normal standard.

Dr. Van de Warker in the *American Journal of Obstetrics and Gynæcology* for July, 1883, gives the results of thirty-one cases of trachelorrhaphy as follows :

Uterine displacement unchanged in .....	16
“ “ removed in .....	11
“ catarrh unchanged in .....	10
“ “ removed in .....	11
Subjective neurosis unchanged in .....	3
“ “ improved or removed in .....	16
Nutrition improved in .....	18
“ unchanged in .....	5

Many cases of course cannot be subsequently followed, and statistics from them cannot be gathered. When the wound is properly healed without sloughing there is usually no scar left either to mar the normal appearance of the cervix, to obstruct delivery, or to render the patient liable to a subsequent laceration. Even where a cicatrix forms it is longitudinal, and at subsequent deliveries does not in the

least interfere with dilatation nor offer any additional predisposition to laceration.

Drs. Goodale, Hunter, Skene, Lee, Emmet, besides many others, have reported, through the medical journals, numerous cases of pregnancy following trachelorrhaphy, with no impairment of the natural continuity of the cervix.

The subsequent history of the operation shows that laceration is no more apt to occur than in one whose cervix has never been torn.

In viewing the effect of the operation on sterility, it must be remembered that many women, from the long continuance of the inflammation consequent upon the lesion, have no doubt been thrown beyond the medical action of any procedure, surgical or medical. The constriction of the tube by bands of tissue left by a former cellulitis; the establishment of salpingitis or ovaritis of some form; the fixation of the pelvic roof and binding down of the uterus, all tend greatly to diminish the possibility of a future pregnancy. Taking this into consideration, the statistics referring to the removal of sterility are very fair.

In the *New York Medical Journal* for July, 1883, Dr. B. F. Baer reports the results, as regards sterility, of twenty-seven cases operated upon by him. Of this number six had reached the menopause or were widows; thirteen had been sterile for from five to sixteen years previous to the operation, and from reasons as stated above probably could not become pregnant. Of the remaining eight, six afterward became pregnant. Dr. Baer thus estimates that in seventy-five per cent. of those in whom there was a possibility of a subsequent impregnation the sterility was cured. I should regard this percentage as too high, for the reason that probably a fair proportion of the thirteen who were excluded from the estimate had not suffered severely enough from the results of inflammatory action to render them necessarily sterile.

In the following number of the same journal, Drs. Githens,

Lee, Montgomery, and Goodell reported numerous cases of pregnancy following the operation.

Dr. Emmet remarks that the effect of trachelorrhaphy upon sterility is good providing the pelvic organs have not been too greatly injured by inflammation; that, after preparatory treatment, pregnancies were of very common occurrence without subsequent laceration.

As the majority of patients operated upon have passed the period in which impregnation is most apt to occur, the actual benefit of the operation upon sterility is not to be measured entirely by statistics, which necessarily include a very large number of cases in which no possible benefit could be anticipated. But, under favorable circumstances there can be no doubt but that trachelorrhaphy, properly performed, exercises a very beneficent local and reflex action upon the sterility as well as upon other symptoms dependent upon a severe laceration of the cervix.

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A BAD CONFINEMENT THAT DID WELL.—  
PUERPERAL CONVULSIONS OF THE MOTHER  
AND ECLAMPSIA OF THE CHILD.

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BY

J. M. LUCAS, M.D.,  
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On September 11, 1887, I was called at 4 A.M. to go several miles into the country to attend Mrs. E. in her first confinement. On my arrival I found the woman in a violent convulsion, with complete loss of consciousness; was informed that this was the third she had had since the child was born, about an hour before. Not seeing any baby in the room, I asked one of the women what they had done with the child. She pointed to the bed and said it was



there. I found it still attached to the cord and placenta retained. As the child was breathing fairly well, I at once tied the cord, severed the connection, and handed the child to an attendant. By this time the spasm had somewhat relaxed, but there was still unconsciousness.

I prepared some belladonna 3d, in water, and had her swallow some. On attempting to remove the placenta I found it adherent, and with considerable difficulty I peeled it loose; had all removed in half an hour.

For several minutes there was quite free hæmorrhage. The spasms continued to recur about every half-hour for several hours, then grew lighter and less frequent. The belladonna was continued; a dose every fifteen minutes—as nearly as the spasms would permit—until there was an improvement; then at longer intervals. By evening the lochia had entirely ceased; had several severe, and a number of lighter spasms during the night, all of which had ceased by morning, leaving the patient semi-conscious, and very weak; had slight lochial discharge, but no action from kidneys since confinement. Prescribed belladonna and apis alternately.

I was then told that the baby had during the night several spasms, and that there had been no action either of its bowels or kidneys since it was born. Prescribed apis 3d.

At my next visit found the mother rational. There had been no spasms since my last call. Secretions doing well, and patient free from fever.

Infant's bowels and kidneys had both acted, and it was free from spasms. Continued at intervals of two hours, belladonna for the mother, and apis for the child, until I dismissed the case, September 17, no further trouble occurring.

## ● EDITOR'S TABLE. ●

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—Our Cuban exchange, the *Cronica Medico Quirurgica de la Habana*, records the first ovariectomy practiced in Porto Rico. The operation was performed for the relief of an ovarian cyst. Unfortunately the woman died on the eighth day. Judging from the various reports of abdominal surgery in this Spanish Journal, during the last few years, laparotomy for the relief of intra-pelvic lesions is attended with great mortality in the practice of the West Indian surgeons.

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—Evidently gynæcological literature will be quite active this winter; several new works on this subject are in preparation. Among them we are anticipating a new addition of Ludlam's standard work. Possibly, also, Dr. E. H. Pratt will add to his laurels by giving us a new work on orificial surgery that will have gynæcological tendencies.

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—During the next year the HOMŒOPATHIC JOURNAL OF OBSTETRICS will take an active part in contributing a large share of the gynæcological literature. Our constantly increasing popularity enables us to promise an enlargement of the space devoted to original articles. We have added to our list of exchanges the leading French gynæcological and obstetrical journals, the only Spanish journal on these subjects, and a number of the German journals, and thus are now in a position that gives superior advantages for presenting our readers with short notes on the progress of our specialties in every prominent city of the old world. We shall, as heretofore, give especial attention to the pathogenesis of new drugs, as developed by provings and cases of poisoning (in so far as they stand in relation to our special subjects), to the verification of the symptoms pertaining to our older remedies, and to the comparison of remedies; all this to the end that we may become more and more able to successfully prescribe internal remedies for many of those diseases of women in which we

now use local applications and mechanical measures. We appeal to our readers for contributions in this direction, especially for short notes on the verifications of drug symptoms.

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—We also hope to establish a "*personal*" column, but for this must depend on the courtesy of the profession in sending us the "whereabouts and doings" of those prominent in the subjects represented by the Journal. Notices of removals and appointments to official positions will be especially welcome. The old school have a national gynæcological and obstetrical association and thus, by their frequent meetings, are enabled to keep track of each other, but, as we homœopaths have no such association (at least in *active* existence at the present date), the Journal will endeavor to keep up a feeling of "good fellowship" by occasional personals.

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—We say, "in active existence," for it is to be hoped that in the near future the American Obstetrical Society may be revived. The first sessions of this society, at which our homœopathic obstetricians and gynæcologists assembled with such hopeful spirits, were so successful that even at this late day we have not lost the belief that the Society can be again called into an active and useful existence.

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—Endothelioma of the ovary (endothelioma ovarii) is so rare a variety of ovarian neoplasm that it is frequently diagnosticated as a dermoid cyst with cancerous degeneration. It is true that endothelioma presents many analogies, with regard to structure, to the microscopic sections of a dermoid cyst, and here, in particular, we have in mind a case recently presented to the gynæcological society of Berlin under the title, "cancerous degeneration of a dermoid cyst of the ovary."

The case was that of a woman of forty-seven. For several months there were severe pains in the right side of the abdomen, fever, emaciation, loss of vital forces. The uterus was pushed to the left by a tumor as large as a foetal head, easily isolated from the uterus. Laparotomy was performed and the tumor extracted.

During removal the tumor was found adherent to the intestine at several points. The tumor contained a yellowish, very fetid mass. At the points of adhesion was found a malignant degeneration. Within the cavity of the tumor were found a mass of hair, epithelial elements, and crystals of cholesterine, from which the diagnosis, dermoid cyst.

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—But, later on, a second examination, made now of sections taken from the hardened tumor, showed that although there was present an association of epithelial elements and connective tissue, as in carcinoma, yet the anatomical disposition of these elements was not precisely similar. For example, the alveoli were not as clearly separated as in carcinoma. Besides, at the limits of the alveoli were found giant cells and fusiform cells in immediate contact with the ambient connective tissue, so that the cell elements of the tumor appeared to be derived therefrom. Finally, other sections afforded proof that the degenerative alterations were dependent upon a diffuse inflammatory proliferation of the *endothelial* elements of the lymphatic spaces of the connective tissue. It should, then, be remembered that endothelioma of the ovary, in conjunction with dermoid growths, is distinct from a cancerous degeneration of the same, and that it arises from *endothelial* proliferation either of the cell elements lining the lymph spaces and channels, or from those of the blood-vessels. Thus it is that Kolaczek terms these growths *angio-sarcoma*, and Leopold calls them *cystic lymphangioma*, according to the place from which they have found the cell changes arising; while *endothelioma* embraces in one term both classes.

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—*The Pharmacology of the Newer Materia Medica* is the title of a new journal placed on our table by George S. Davis, of Detroit. From the first six numbers we gather a number of interesting facts in relation to those newer drugs with which old-school physicians have been experimenting. Of course, all the recommendations put forth in favor of these new drugs are based upon clinical experience and are entirely empirical. Then, too, some of the facts reported are decidedly apocryphal, such as reported

cures where local treatment has been used in connection with an internal remedy. But, leaving aside all these considerations, we have occasion to be grateful to the publishing house of George S. Davis for placing within such easy access an aggregation of facts that we hope will, in the future, lead to homœopathic provings of these new drugs. We will briefly point out a few of these remedies which seem to promise to enter soon into our special fields.

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—*Adrue* (*Cyperus Articulatus*) is a tropical remedy described as "of surprising worth in checking emesis, whether the vomiting of pregnancy, yellow fever, or indigestion." Dr. Kitchen, of East Saginaw, Mich., reports it of service in whooping-cough.

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—In *Ailanthus glandulosa*, we recognize an old friend of scarlet fever fame, but here the old school introduce it as a remedy for chorea. In the case of chorea (in a girl of thirteen), related as cured, there were "violent, irregular motions extending to every limb. She could speak only 'yes' and 'no,' and even these would require some minutes; she would wriggle herself out of her chair and off the bed unless held firmly." Ten-drop doses of *Ailanthus* were given every two hours, producing early relief and a cure. From the provings of *Ailanthus*, we are satisfied that it has a special action on the cerebro-spinal axis, but we are not aware of any cases of chorea having been reported as cured by this remedy administered under homœopathic management.

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—When reading the description of *Thuya occidentalis*, under the name of *Arbor vitæ*, we are unable to suppress a smile, especially when we find the following very lame explanation of its curative action in cases of sycotic vegetation: "Thus far, *thuya* appears to have been employed empirically only [and always will be by the old school], but it would seem, on reviewing the affections in which it had been of service, that its action may be explained by a property somewhat similar to that possessed by *ergot*, namely, of causing contraction of unstriped muscular

fibres. This would explain, in some degree, its alleged power of controlling capillary hæmorrhage, and the growth of vascular tissues, like cancer and condylomata." One reporter, Dr. H. C. Noble, is honest enough to avow that his attention was called by a homœopathic physician to the use of thuya in spermatorrhœa. Dr. Noble claims to have used this remedy in about thirty cases of spermatorrhœa, with only one failure to cure. But, soon after this favorable report and honest avowal of its homœopathicity to the disease in question, we come to the opinion of a more scientific (?) man, who utters the old cry of "mistaken diagnosis." Among reports on the use of thuya in condylomata, Dr. Constantine Paul cites the cure, within fourteen days, of non-syphilitic warts, which covered the genitalia of a woman, by the use of the tincture in 3 ss, 3 j doses, administered two to three times a day.

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—Coming to *Berberis aquifolium* we find, from the clinical descriptions given, that its so-called "alterative" effect (as evidenced by the success with which it has been used in cutaneous and syphilitic diseases) points out that it may be found to have a pathogenesis differing in many ways from that of the other barberry, the one so familiar to us, *Berberis vulgaris*. The latter remedy we rarely think of in uterine trouble or in menstrual difficulties unless these disturbances are linked with the peculiar urinary symptoms of the drug. The former remedy, *Berberis aquifolium*, however, according to the good reports on its use in leucorrhœa, amenorrhœa, and dysmenorrhœa, seems to have an independent action on the female genitalia. While the old school characterize it at present as a "female regulator," we hope that the homœopathic profession will take it in hand soon and give us provings that will either lead to more certain indications for its use in gynæcology, or prove its action to be identical with that of *Berberis vulgaris*.

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—With regard to *Cereus bonplandii*, we had some time ago in this journal an article, by Dr. Phil. Porter, on its use in cases where the sympathetic nervous system was reflexly involved in uterine diseases. This point is also brought out by some cases,

under *Cereus bonplandii*, in the *Pharmacology of the Newer Remedies*, which we have now under discussion. Since Dr. E. M. Hale has undertaken the task of obtaining provings and information of the *Cactæ* during the next year, we may be assured that his energies will afford us a splendid paper on this subject.

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—The last number of *The Pharmacology* which we have received contains a vast fund of information on the subject of cocaine. Here we find a full record of all the cases of poisoning that have occurred from the use of cocaine, and also the physiological action of this alkaloid as developed from experiments on animals; all of which will be utilized, without doubt, in the near future, in the homœopathic treatment of nervous diseases. Possibly a careful proving by women may lead to its employment in some of those nervous symptoms which arise by reflex irritation in uterine and ovarian affections.

## ● GOLDEN GRAINS. ●

—The breath of a healthy infant or child should be odorless, or, as the nurse will say, "sweet," except, perhaps, immediately after taking nourishment, when it may, for a short time, have the smell of milk or any special food eaten. The persistent presence of an odor is therefore abnormal, and indicates disease.

—Although *apis* is one of our best remedies in tubercular meningitis, yet it must be remembered that it is very similar to *sulphur*. Both are also indicated in cerebral symptoms arising from repercussion of some eruption—sulphur, if it is a chronic eruption, and *apis* if it is an acute one. *Apis* is indicated when the little patient starts up with a piercing shriek. Under sulphur the child awakes with a cry, but this is never the *cri encephalique*, so characteristic of *apis*. With sulphur, the patient does not sleep at all, or sleeps in cat-naps. With *apis*, the child appears drowsy but does not sleep and rolls from side to side.

—Cough in children is sometimes produced by the pressure of dried cerumen in the ears, especially that which does not lie firmly attached and is moved partly by the movement of the lower jaw and partly by the stiff hairs of the meatus. Foreign bodies in the ear may produce similar phenomena. It should also never be forgotten that the reflex action from the otic tract may produce even more serious trouble than cough, for examples have been cited of vomiting, convulsions, and even epileptiform attacks, dependent upon the presence of a polypus or of a foreign body in the ear.

—*Graphites* is adapted to chlorosis where the patient is always cold, is anxious, apprehensive, and sad, from forebodings of something indefinable which she fears is going to happen. The menstrual flow is late, pale, and scanty. There is also a watery leucorrhœa which sometimes is excoriating. The patient complains of rush of blood to the head, and of throbbings through the body on lying down at night. But most characteristic is the rough, harsh, dry skin, with the appearance of little pimples on the body, which are especially apt to be worse at the menstrual periods.

—The general causes of infant mortality are : 1st. Hereditary, viz., syphilis, scrofula, tuberculosis, excessive nervous irritability, etc. 2d. Those due to the child's environments, too little or too much care, exposure or over-protection, insufficient or too much food. These causes result in dyspeptic ailments, intestinal disorders, contagious diseases, marasmus, convulsions, capillary bronchitis, pneumonia, etc. While "general debility" is not considered as a separate and distinct affection, the term is a convenient one to use to designate that condition which follows (especially in our cities) many cases of intestinal diseases, whooping-cough, measles, scarlet fever, and diphtheria. Muscular and nervous debility are frequently associated with the ailments of city children nowadays, and, this being so, there is more need of recuperation in the summer than heretofore.

—Dr. V. Paulet (*Journal de Méd. de Paris*) reports a number of cases of hysteria treated with *simulo* in which it appeared to have decidedly good effects. He also employed the drug in a



case of ovaritis with severe pain, and one of double pregnancy accompanied by nervous palpitations, violent headache, and complete insomnia, and obtained absolute relief in both cases. He believes that it may be useful in epilepsy and in chorea also.

—The close proximity of the fallopian tube of the right side and the vermiform appendix renders the latter organ extremely liable to become involved in a peritonitis extending from the tube, and the general and local symptoms are so nearly like those of appendicitis and typhlitis arising from perforation that, unless this element of tubal cause be recognized, frequent mistakes in diagnosis and treatment will be made.

—A young woman (*Wien. med. Presse, L'Art Méd.*), attacked by subacute rheumatism, only found relief after having taken salicylate of soda. Having renewed the dose of this, several days in succession, she began to feel pain in the sacral region; the menstrual period appeared eight days too soon and lasted longer than usual. As her rheumatism was obstinate and prolonged during several months, the patient made similar experiments several times; the hæmorrhages and lumbo-sacral pain increased until the patient preferred to undergo the sufferings of her rheumatism rather than expose herself to the action of the drug.

—In pregnant women who have heart disease, abortion is very likely to occur as a result of venous engorgement and consequent defective placental circulation, and hence it may happen in any of the heart lesions where this condition of affairs exists.

—Dr. J. B. Carney (*Australian Med. Jour.*) relates a case of vomiting of pregnancy relieved by the application of cocaine to the cervix uteri. On vaginal examination the uterus was found markedly anteflexed; the cervix was much swollen, and the surface, especially about the os, eroded and bled freely when touched; the erosion extended into the cervical canal. The whole of the vaginal wall, the cervix, and cervical canal, to the extent of about one inch, were painted with a saturated solution of cocaine and a suppository containing a grain of cocaine and a quarter of a grain of morphia was placed against the os uteri. The patient (who had been vomiting severely for ten days and unable to retain the least nourishment) did not vomit for eight

hours after the cocaine was applied ; at the expiration of that period vomiting recommenced, but was less severe. The application of cocaine was repeated, after which she made an uninterrupted recovery.

—M. Saint-Philippi, of Bordeaux (*Concours Méd.*), insists that itching is frequent in scarlatina ; he points out the fact that almost all classical authors have neglected to signal, the possible existence of pruritis in this eruptive pyrexia, so that some physicians hesitate to make a diagnosis of this disease if the patient complains of itching. According to this author, this symptom should be given importance in a prognostic point of view : Cases of scarlet fever in which pruritis is prominent are never grave.

—Dr. St. Huzarski (*Centrbllt. f. Gyn.*) describes a case of severe anæmia following a tedious labor. The uterus contracted well at first, but shortly after delivery it relaxed and a moderate hæmorrhage took place. The patient presented alarming symptoms of collapse. Hypodermatics of ether and camphor gave only temporary relief. The symptoms finally became so alarming that, as an emergency, a large rectal injection of a solution of common salt was given. Improvement was immediate, the pulse became stronger, and the color returned to the lips. Within an hour the patient was again in a condition of imminent death. A subcutaneous injection of 1000 grammes of a 6 per cent. solution of sodium chloride was given. Improvement was again immediate and the patient went on to convalescence.

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## ● GYNECIC ETCHINGS. ●

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—Dr. Pollacsek, of Buda-Pesth, has published in the *Centralblatt für Gynäkologie*, some researches on inflammation of Cowper's duct. Four varieties of "Bartholinitis" are distinguished :  
 1. Simple catarrh of the duct, in which suppuration may occur, but not of specific origin. 2. Gonorrhœal catarrh of the duct, in which the gland is rarely involved. Suppuration is rare, but when occurring in prostitutes is chronic and obstinate. 3. Idio-

pathic suppuration of the gland, which is acute, and may happen in children. 4. Gonorrhœa of the duct with abscess of the gland. The abscess cavity following this last variety is in many cases very difficult to close and the duct of the gland may become a fistulous tract.

—The *British Medical Journal* records a case of placenta prævia which was successfully treated by the introduction of a large piece of solid alum up against the os, and maintained in close contact with it by a vaginal tampon. The case is presented by Dr. Dempsey, who claims the following advantages. 1. It produces constriction of the vaginal sinuses by hardening and contracting the uterine fibers in the lower segment of the uterus, against the outer surface of which it is in contact. 2. It appears to assist in causing thrombosis of the sinuses. 3. It produces a tenacious mortar-like coagulation of the effused blood, which acts as an additional tampon in the vagina. 4. It does not prevent dilatation; and, 5. From limited experience it appears to obviate the necessity for the usual operative measures required in placenta prævia until the os is sufficiently dilated to permit them with safety.

—Paget's disease of the nipple has been looked at in the light of various interpretations. Paget described it as a "chronic inflammation," but later authorities have attributed it to other pathological conditions. By one it has been called, "chronic eczema"; by another we have it designated as a peculiar form of epithelioma, and, lastly, Darier in 1889 declared that he had discovered a parasite which caused this disease of the nipple. More lately Paget's disease has been made a subject of exhaustive study by L. Wickham (*Annal. de dermatologie et de syph.*, 1890). Wickham confirms the results of Darier in finding that the disease is due to single-celled parasites of the order of cocci or psorosperma. The special feature of Wickham's work, however, is the excellent clinical description which he gives. It is characterized by a chronic inflammation of the skin, and of the glands and their ducts, followed by the formation of an epithelioma. Though most often located on the breast, in one case it has been seen upon the scrotum. It is rare before forty years of age; then it de-

velops slowly and becomes epitheliomatous after from two to six years, though it may become so in a few months, or not for twenty years. It most often affects the right breast, beginning always at the nipple. At its upper surface there are corneous concretions, little tenacious crusts, beneath which there exists at first an itching, erythematous redness, and afterwards ulceration and fissures. From this time the nipple shows a tendency to retract. The areola is progressively invaded, and we have a bright red surface, moist, desquamating or crusted in places, finely mammillated, bleeding easily, and sharply circumscribed. Upon the surface there are disseminated islands of a brilliant red and dry cicatricial appearance. Teleangiectases may be seen here and there. The process seems to be superficial and gives to pressure a slight papyrus-like induration. Burning and itching sensations give the disease the appearance of eczema rubrum, but in doubtful cases close observation of the border of the disease will decide the doubt. It is always sharply defined, most often taking the form of a red or pale rose slight packing raised upon the sound skin. Upon its surface are dilated capillaries, and at times there is a slight desquamation beyond it. The disease slowly extends over the areola upon the breast, taking often a rounded or oval shape. The nipple is then contracted completely, and frequently is the seat of ulceration. At times it begins as a hard lump deep down in the skin. Once established as a cancer, it develops more rapidly. Ganglionic enlargement only occurs late in the disease as a rule.

—Pinzani (*Arch. d'obst. et gyn.*) extracts from the literature of antipyrine, and from a series of observations of its action upon the parturient and the puerperal uterus, the following conclusions :

1. Antipyrine given during labor in stomach doses of forty-five grains, or in hypodermic doses of fifteen to twenty grains, impairs the contractility and retractility of the uterus. The effect of the drug begins within a half hour after its administration and reaches a maximum during the second and third half hour when exhibited hypodermically, during the fourth and fifth when given by the mouth. The influence of the drug upon the uterus is greater in proportion as the dose is large and its administration early in the labor.

2. The use of antipyrine in therapeutic doses during the puerperium also weakens the action of the uterus in proportion to the dose employed.

3. Antipyrine has the power to diminish for a brief time the pain caused by the contraction of the uterus, either during labor or the puerperal period. Just as in the case of many other drugs our old school friends at last begin to realize that the evil effects of antipyrine in the parturient or puerperal condition are not compensated by its advantages.

—Dr. Swiecicki, of Posen, is apparently the first who has published the therapeutic results of the use of Aristol in gynæcology (*Gazette de gyn.*, July, 1890). In his practice he has employed this new antiseptic in the form of a 10 per cent. solution in oil, saturating tampons for vaginal use. Medicated pencils were also introduced into the uterine cavity. In the therapeutic results obtained by Dr. Swiecicki, in twenty gynæcological cases treated by the use of *Aristol* exclusively, there are noted the cure of endometrites, erosions of the cervix, and eczema of the vulva. Commenting on these facts, in the same journal, Dr. Gaudin remarks that he has employed pure Aristol, in powder, on tampons, in a case of epithelioma of the cervix. At the end of fifteen days treatment all hæmorrhage had disappeared, the fetid ichor was arrested, and the lesion had a red and clean aspect, which it never had previous to the employment of Aristol. According to the experiments of Prof. Langgoard, of Berlin, Aristol is not decomposed in the system, as is thymol biniodide and iodothymol, from the excess of iodide of sodium contained in these drugs. This property makes Aristol especially valuable in gynæcology (where we have such a large area of absorbent surface) as it may be used very freely without fear of intoxication from absorption.

—J. Bland Sutton attributes early rupture in tubal pregnancy to the formation of an apoplectic ovum suddenly distending the tube by the escape of blood into the chorion. He also very properly urges that no intra-peritoneal hæmatocoele should be attributed to ruptured tubal pregnancy unless the presence of foetal membranes or of a foetus could be demonstrated.

—All the Juglandaceæ seem to produce a condition of the blood in which that fluid becomes dark and pitch-like in color. Of all this family there is only one, *Juglans regia*, which holds any relation to gynæcology. In this connection it is said that *Juglans regia* is useful for menses coming on too soon, and composed of nothing but black coagula.

—Dr. C. C. Sherman reports the case of a woman bitten by a centipede (*Scolopendra Morsitans*). The following symptoms were prominent.

*Head*.—Vertigo, with blindness, worse in the morning.

*Stomach*.—Nausea and vomiting; unable to retain either food or liquid.

*Back*.—Terrible pains in back and loins, spasmodic and irregular, at times extending down the limbs. Pains returned every few days for three weeks, commencing in the head and going out at the toes. "Resembled labor pains as nearly as anything I ever saw."—*Med. Advance*.

—Dr. R. M. Hutchins has been using Ponca with some success in gynæcological practice. He claims that it has a more decided *alterative* action upon the uterus and uterine mucous membranes than any known remedy [in old-school experience]. Under its internal administration he has seen "long standing ulcerations heal, foul discharges cease, a spongy, inflamed, and enlarged uterus reduced in size, and become firm and healthy." In subinvolution it is claimed that it is invaluable, soon relieving such symptoms as headache, backache, bearing-down sensations, bladder troubles, and other conditions that are consequences of an enlarged uterus. The difficulty is that the doctor seems to have used this remedy only in combination with other drugs such as caulophyllin, helonin, etc., that are also indicated in such conditions as he describes. If its action upon the uterus and appendages is as powerful as is claimed, a proving of ponca would be a valuable addition to our *Materia Medica*.

—Dr. Bantock, of London, reports a series of cases of ovariectomy in which the mortality of the last 100 was only 4 per cent. He also reports himself as having discarded Listerian methods, now restricting himself to pure water and strict cleanliness.

## BOOK REVIEWS.

IRREGULARITIES OF THE TEETH AND THEIR TREATMENT. By EUGENE S. TALBOT, M.D., D.D.S. P. Blakiston, Son & Co., Philadelphia, 1890.

The second edition of Talbot's work has been greatly enlarged and improved, and now presents a really classical treatise on this branch of dentistry. When we reflect on the close relationships between perfectly developed teeth and a healthy digestive apparatus, it will at once be seen that books of this nature hold a very important place in the *armamentarium* of the family physician. It is certainly our duty to arm ourselves with sufficient knowledge to enable us to make suggestions that will lead parents to attend *at once* to deformities in the development of the arch of the palate, of the alveolar processes, and of the eruption, not only of the permanent teeth, but also of the first teeth. The book is full of valuable information on the constitutional causes of irregular teeth, especially those arising from diathesis, from malnutrition and, from its opposite, over-stimulation. In short, the specialist in diseases of children cannot afford to be without this work.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCE. Edited by CHARLES E. SAJOUS, M.D., and seventy associate editors. F. A. Davis, Publisher, Philadelphia, 1890.

Sajous's yearly report of the progress of the general sanitary sciences throughout the world has become one of those works for the appearance of which we anxiously wait every season. Its volumes of reference are so extensive there is no danger that any matter of interest, however small, can escape incorporation within its pages and, as we place it on our shelves, we feel here is a work that contains information embracing *facts* sifted from hundreds of new books, journals, and monographs. Gynæcological and obstetrical subjects, and diseases of the newborn, all together, occupy the larger half of Volume II. Diseases of the tubes constitute a large share of the late literature on diseases of women, and this portion of the work is particularly valuable. In "diseases of pregnancy" the literature consists largely of clinical cases. More interesting is "operative obstetrics" and here the interest is largely centered in a valuable *résumé* of Cæsarean and Porro's operations. Diseases of children does not receive a special section and the various affections to which they are liable are scattered through several volumes; a division, the wisdom of which in a reference work of this character, we question. Taken as a whole the five volumes constitute a monument that marks

the industry of the editors. But, if the publisher designs it as a "Universal" yearly reference work he must, in future, include within its pages the original matter appearing in homœopathic publications, otherwise it appears as a work with a bias, for we could point out many valuable articles, by writers in our current literature, that have been excluded.

**DISEASES OF THE RECTUM AND ANUS.** By CHAS. B. KELSEY, A.B., M.D. William Wood & Company, New York, 1890.

Dr. Kelsey's work appears before us in a third edition. We have always regarded this book, even in its first edition, as one of the most valuable monographs on diseases of the rectum, and now that it has been, to a great extent, rewritten and enlarged, to accommodate the later advances in the surgery and pathology of this part of the body, it becomes a standard reference work. The chief defect of the book is the failure to notice the original work which Dr. E. H. Pratt has been doing in this direction.

**REFORMATION IN THE PRACTICE OF MEDICINE.** By J. E. MACNEIL, M.D.

This small work is an endeavor to extend the influence of Dr. Burggraave's *dosi*-metric system of medicine. Perhaps, some day, we may have a few words to say on the use of Dr. Burggraave's alkaloids in gynecological practice; we find that triturations prepared from some of these alkaloids are certainly reliable.

**THE NEW TREATMENT OF PERITONITIS.** By EMORY LANPHEAR, M.D.

Within the eight pages contained in this reprint from the *Kansas City Medical Index* the plea for early operation is taken up, and from an experience with eight cases the author concludes that whenever peritonitis has gone on to that stage where the formation of pus is known, or even suspected, to have taken place, abdominal section and drainage are imperatively indicated; that where the existence of tubercular peritonitis is diagnosed, or even strongly suspected, operation (exploratory incision) is justifiable.

**PRACTICAL SANITARY AND ECONOMIC COOKING.** By MRS. MARY HINMAN ABEL.

This is one of the "Lomb prize essays" called out by the American Health Association. We give it notice chiefly for the fact that it proves itself of such great value to the busy housewife, who so often asks the question, "What can we get the children to eat that is healthy and tempting, and yet out of the line of harmful delicacies?"



**EXTRA-UTERINE PREGNANCY.**

We have in a brochure of some fifty pages a collection of papers and discussions on this subject occurring in the transactions of the Baltimore Obstetrical and Gynæcological Society. A most worthy paper is that of Dr. Mittenberger, and we cannot refrain from quoting his opposition to Tait's views on this subject. "We are compelled to insist that these cases of ovarian pregnancy positively disprove Mr. Tait's assertion that conception normally takes place only in utero, and that the spermatozooids can never traverse the tube in its normal condition, on account of the cilia working in the opposite direction. He further states, as a matter of logical sequence, that it is only after desquamative salpingitis that the spermatozoa can reach the ovules in the tube, and that this is the cause of tubal pregnancy.

"Now it is positively known for years (Bischoff and others) that the spermatozoa pass out through the tube upon the ovaries, and into the abdominal cavity in the lower animal. Mr. Tait asserts that in the lower animals the tubes differ from those in the human being, and have no cilia, while we know perfectly well they have."

**ESSENTIALS OF DISEASE OF THE EYE, NOSE, AND THROAT.**

SANDERS's very excellent "Question Compend" are gradually extending to all departments of medicine. The present little work will fulfill a useful purpose in coaching the student in the subjects with which it deals.

**STRICTURE OF THE RECTUM. By CHAS. B. KELSEY, M.D.**

In this pamphlet the author issues a short treatise on his experience with rectal stricture. Some new instruments are shown, and all the different methods of operating are fully explained. Gynæcological surgeons find their work coming into such intimate relations with rectal surgery, of late, that works of this kind are quite welcome to our pages.

**IGIENE DELL' ORECCHIO.** Per Il Cav. Prof. VINCENZO COZZOLINO. Naples, 1890. **IGIENE PUBBLICA E PRIVATA NELLA DIFTERIA.** Per Il Cav. Prof. VINCENZO COZZOLINO. Naples, 1890.

The first of these two brochures, "Hygiene of the Ear," is quite valuable from the precepts it contains on the care of the ears of the new-born and of very young children. It should be remembered that the first earaches of children are not such simple things as the family physician generally believes them to

be, but that catarrhal or suppurative inflammations of the ear in childhood are very apt to be the precursors of a trouble that may extend over long periods of time and produce deafness at an early age, if not immediately and properly treated.

The second of Professor Cozzolino's works is a reprint from *La Terapia Moderna*, containing a careful study of the public and private hygiene of diphtheria.

ON PERINÆORRHAPHY. By FANCOURT BARNES, M.D.

Dr. Barnes issues a little work, advocating the flap-splitting operation in the repair of lacerated perineum, in which he includes very practical directions for the performance of this surgical procedure. He advises late operation, four or five weeks after the rupture, as he has often seen a thin superficial band of tissue resulting from the immediate operation, that masks the original rent through the sphincter.

GENTRY'S CONCORDANCE REPERTORY OF THE MATERIA MEDICA. Vol. III. Abdomen, Anus, Rectum, and Stool, Male Sexual Organs. Cloth, \$6; leather, \$7; half morocco, \$7.50. A. L. Chatterton & Co., New York, 1890.

Next to the future volume of this Repertory, which will contain female sexual organs, we consider this issue of Gentry's work as having the most important bearing on gynæcology of the whole series. That this is so will not be doubted, if one devotes sufficient time to the examination of the two hundred and twenty-nine pages given to those symptoms which refer to the abdomen. When one considers that a very large portion of the symptoms produced by disturbances in the female genitalia are referred to the abdominal region, it will be at once noted that this portion of the Repertory is almost a *chef-d'œuvre* for the gynæcologist. And just here, there are wafted to memory two remarks, one on the utility of repertories, the other deriding, the one representing the grossly pathological side of prescribing, the other the finer shades of the similarity of drug symptoms to disease.

But, without raising any question for discussion, we only wish to note the first remark, that of a hard-working student of *materia medica*, who upon delivery of the first volume of Gentry was able to select at once a remedy which cured for him a case that had obstinately resisted all treatment for months, a cure which was worth more than three times the cost of the six volumes of this work.

The remainder of the work, "ANUS, RECTUM AND STOOL, URINE AND URINE ORGANS," will be of value both to gynæcologists and to specialists in pædology, while the "MALE SEXUAL ORGANS" will interest the whole profession alike.

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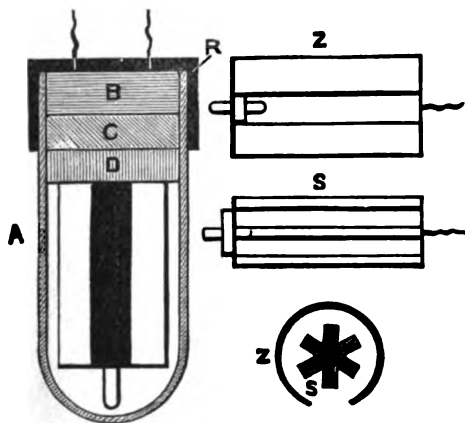
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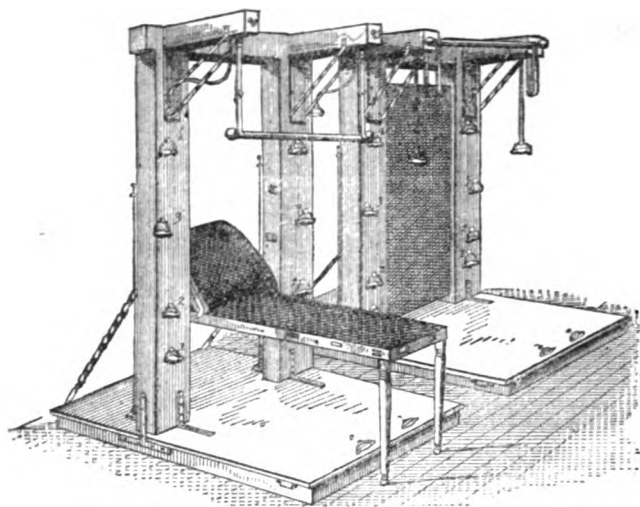
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Pil. extract grindelia robusta, 3 grains, sugar- or gelatin-coated; dose, 1 to 4 pills.

**QUEBRACHO** is an Argentinian drug. The bark contains the active medicinal principle. The most eligible form for its administration is the fluid extract. In spasmodic asthma it has often brought about speedy relief from the paroxysms.

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**YERBA SANTA** is found throughout California and on the Pacific coast. The leaves are the part used. We supply the following preparations of the drug.

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Fluid yerba santa aromatic, for making syrup yerba santa aromatic; dose, 15 to 60 minims (1 to 4 C.c.).

Solid extract; dose, 3 to 12 grains (.2 to .8 grm.).

Syrup yerba santa comp.; dose, 1 to 4 fluidrachms (4 to 16 C.c.).

Glycerole yerbine comp.; dose, 1 to 3 fluidrachms (4 to 12 C.c.).

Glycerole yerba santa; dose, 1 to 2 fluidrachms (4 to 8 C.c.).

Lozenges yerba santa comp.; dose, 1 to 2 every three hours.

Pil. yerba santa ext., 3 gra.; dose, 1 to 2

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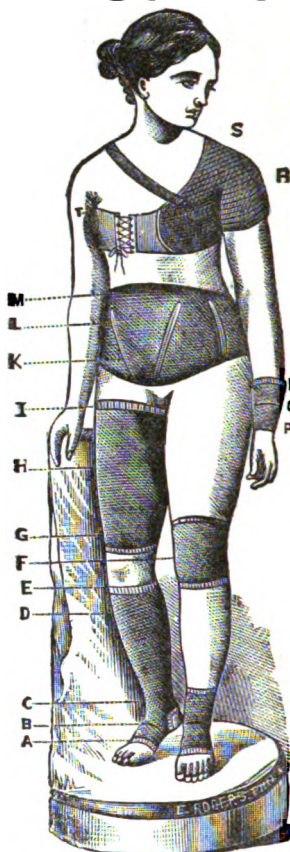
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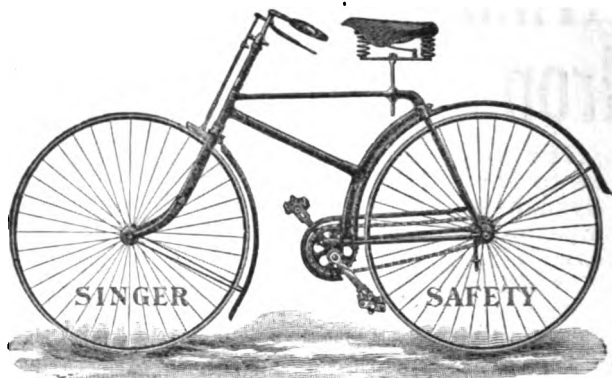
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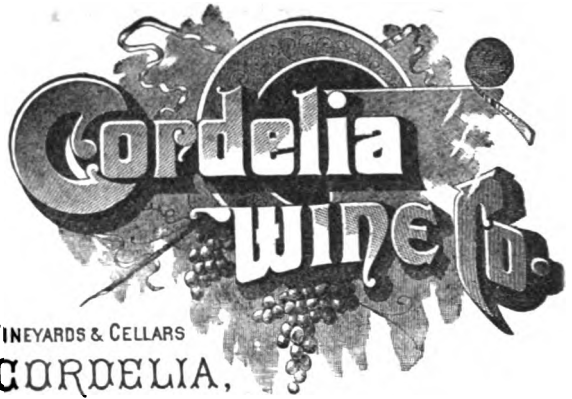
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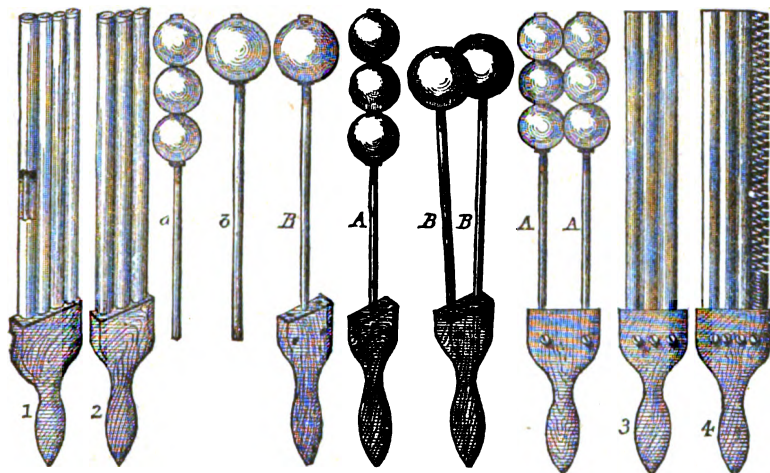
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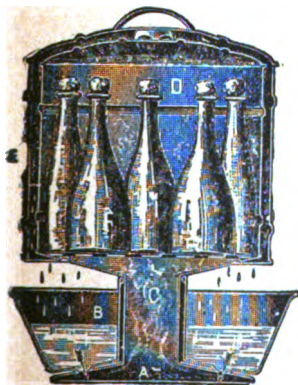
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
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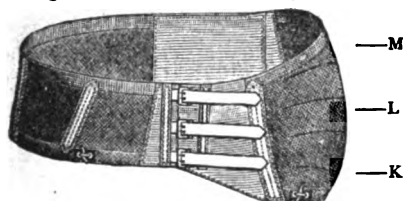
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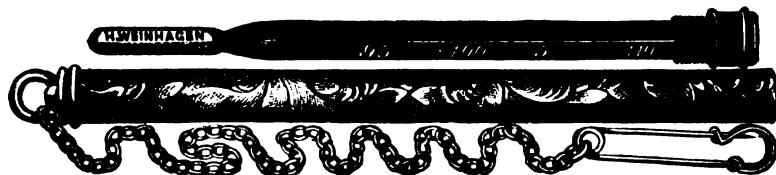
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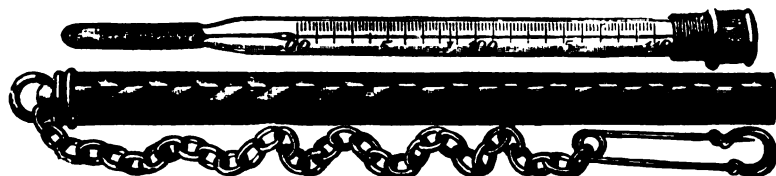
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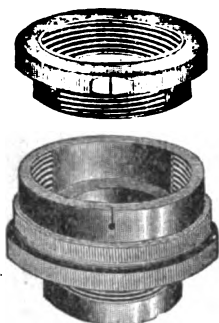
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# An Open Letter to the Medical Profession

## THE INFANT FOOD PROBLEM SOLVED.

NEW YORK, May 1, 1890.

*The Annual of the Universal Medical Sciences for 1889 says: "A perfect Infant Food is still a desideratum; such a food will probably be evolved in the mind of some manufacturer who understands the physiology of infantile digestion and the chemistry of milk. A substitute for human milk to approximate the latter closely should be made entirely from cow's milk, without the addition of any ingredient not derived from milk."*

*"But not alone do we demand that these Milk Foods contain the equivalent of the solids in human milk, and especially of the albuminoids derived from milk, but that the latter be gathered with the utmost care from properly fed animals, transported with the least possible jolting to the factory, maintained during its transit at a low temperature, then transferred to an apparatus for sterilization, and immediately after the latter has been accomplished reduced to the dry state, in order to prevent the formation of those organisms which Loeffler, Pasteur, and Lester have found to develop in fluid milk after boiling under an alkaline reaction. If such a preparation be put into air-tight and sterilized jars, all will have been accomplished that can be done to render the food sterile, and thus fulfill the chief indications in the prevention of the most serious gastro-intestinal derangements."*

*"Such a food, too, would have the advantage of being easily and rapidly prepared by addition of sterilized water, affording an altogether sterilized food."*

To the Medical Profession at large, we submit for examination and trial the perfected Milk Food known as LACTO-PREPARATA. We claim that LACTO-PREPARATA is an ideal Infant Food, and that it fulfills the above requirements in every particular, except the partial substitution of cocoa-butter for unstable milk-fat. This substitution was made by advice of Prof. Attfeld, London, who made extensive tests of its food value and digestibility in the London Hospital for Infants.

LACTO-PREPARATA is made from cow's milk evaporated in vacuo a few hours after it leaves the udder. In order to have the product correspond in composition with breast-milk, sufficient milk-sugar is added to bring up the carbohydrates and reduce the albuminoids to a proper proportion (17 per cent.). The casein is partially predigested (30 per cent.), and the remaining portion is rendered like human milk in character and digestibility. The ingredients are perfectly sterilized and placed in hermetically sealed cans; the powdering, bolting, and canning are done in an air-tight room, all air entering and leaving this room is forced by a blower through heavy layers of cotton. LACTO-PREPARATA is adapted more especially to infants from birth to six months of age; and by the addition of water alone represents almost perfectly human milk in taste, composition, and digestibility.

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